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Editor-in-Chief,
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Dear Professor Lian-Sheng Ma,

We are grateful for the comments and the opportunity to improve our manuscript. We have responded to the points raised by the reviewers and the editorial comments and have submitted a version with the changes highlighted. We have included a summary of our responses below.

Peer review report:

Reviewer #1:

The SAME-TT2R2 model(score ≥ 2) was proposed a few years ago to assist clinicians in identifying patients that may not achieve good warfarin control(TTR). Interestingly, this study suggested that high HAS-BLED score (≥ 3) was a significant predictor of poor TTR.

1. There are three suggestions. Firstly, in the statistical analysis section, the factor “chronic kidney disease” was repeated, and was not mentioned in liver disease/function;

Response: We thank the reviewer for pointing this out. None of the patients had liver disease at baseline. We have added this information under Table 1: Baseline characteristics.

Table 1. Baseline Characteristics

Baseline characteristic	All patients (n=420)	TTR <60% (n=178)	TTR $\geq 60\%$ (n=242)
Age, years			

mean(SD)	65.7 ± 10.9	65.7 ±10.8	65.7±10.9
Median(IQR)	67 (15)	66 (14)	67 (15)
Male	227(54.0)	99(55.6)	128(52.9)
Female	193(46.0)	79(44.4)	114(47.1)
Ethnicity			
Malay	210 (50.0)	96(53.9)	114(47.1)
Chinese	179 (42.6)	64(36.0)	115(47.5)
Indian	26 (6.2)	16(9.0)	10(4.1)
Others	5 (1.2)	2(1.1)	3(1.2)
Comorbidities			
Diabetes Mellitus	170 (40.5)	85(47.8)	85(35.1)
Hypertension	291 (69.3)	128(71.9)	163(67.4)
Ischemic Heart Disease	90 (21.4)	48(27.0)	42(17.4)
Peripheral Vascular Disease	8 (1.9)	2(1.1)	6(2.5)
Stroke/Transient Ischemic Attack	49 (11.7)	20(11.2)	29(12.0)
Deep Vein Thrombosis/Pulmonary Embolism	2 (0.5)	1(0.6)	1(0.4)
Heart failure	27 (6.4)	12(6.7)	15(6.2)
Chronic Obstructive Pulmonary Disease/Asthma	22 (5.2)	8(4.5)	14(5.8)
Chronic Kidney Disease	49 (11.7)	28(15.7)	21(8.7)
Dyslipidaemia	125 (29.8)	47(26.4)	78(32.2)
Chronic Rheumatic Heart Disease	17 (4.0)	10(5.6)	7(2.9)
Liver Disease	0 (0.0)	0 (0.0)	0 (0.0)

2. Secondly, the cutoff values of abnormal lipid panel were not mentioned clearly to define dyslipidemia;

Response: We thank the reviewer for pointing this out. All information on comorbidities were according to information written in the medical records. We have added this information under methodology section.

“All AF patients under Warfarin Medication Therapeutic Adherence Clinic (WMTAC) follow-up between 2014 to 2018 were included. The electronic Hospital Information System (eHIS) was used to extract patients’ demographics, comorbidities, information related to warfarin therapy, and INR readings. Baseline comorbidities were retrospectively retrieved according to available medical records in eHIS.”

3. Finally, a target INR range between 2.0 to 3.0 is generally recommended for warfarin, however, those receiving warfarin for aortic or mitral valve replacements need the higher target INR(2.5-3.5),which is not mentioned in this study.

Response: We thank the reviewer for pointing this out. In this study, only patients with atrial fibrillation were included as mentioned in the methodology. Thus, the target INR range were between 2.0 to 3.0. We have added this information under methodology section.

“For patients with AF, the target INR range were between 2.0 to 3.0. TTR is defined as an estimate of the average time that a medication is dosed with optimal efficacy and safety ⁽⁴⁾.”

Thank you for your consideration of this manuscript.

Sincerely,
Siew-Ling Lee,
Thien-Jian Ong,
Wardati Mazlan-Kepli,
Annuysia Mageswaran,
Kai-Hsin Tan,
Abdul-Muizz AM,
Robert Cronshaw