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Appraisal Correspondence

Trial quality was transparent

We are pleased to respond to the letter written by Dr Redfern and Dr Briffa. First, we used the PEDro scale to rate the quality of included trials in our meta-analysis. The score of included trials in our systemic review was at least 4, half of them were 6 or 7, and the average was 5.8 (SD 1.2). The average PEDro score of trials of physiotherapy interventions published in the same years as the included trials (ie, 1997-2008) was 5.0 (SD 1.5) (scores downloaded from PEDro on 17/7/2010). Therefore we do not feel that the trials were of particularly low quality. We agree that readers should consider the quality of the included trials and we presented the scores in Table 2 for this purpose. We also agree that trial quality could have been higher and that there is definitely a need for high-quality large scale randomised trials focusing on the effect of resistance training in patients with chronic heart failure.

As stated in our Data Analysis, heterogeneity was examined first and the meta-analysis of each outcome was conducted with the appropriate model. We put the major significant finding in the title and conclusion but also pointed out the limitations. We agree with Dr Redfern and Dr Briffa that readers should be reminded that the benefit we found of

resistance training on six-minute walk distance was based on the results of two studies (as we stated in the Discussion).

We thank Dr Redfern and Dr Briffa and agree that some studies could improve their study design by using concealed group allocation and by blinding investigators to group allocation while measuring outcomes. However, the comment on the diagnosis of chronic heart failure was somewhat misleading. As we know, heart failure is a clinical syndrome characterised by signs and symptoms of exertional dyspnoea due to structural and/or functional heart diseases with a range of left ventricular ejection fraction (LVEF) (Libby et al 2008). Some discrepancies in LVEF could be possible.

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