Review of: "Arthritis in East Africa: An Observational Study"

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Potential competing interests: No potential competing interests to declare.

I read the manuscript of Catherine Kuo et al entitled “Arthritis in East Africa: an observational study” with interest.

The authors aimed to describe the prevalence of MSK diseases found in people with limited or no access to regular clinical care across five rural regions in East Africa (three centres in Zambia and two in Kenya). Information and data on the frequency of osteoarthritis, rheumatic diseases is lacking in East Africa.

They decided over a four-week period to propose consultations in Zambia and Kenya and assessed the percentage of patients who consulted with MSK issues. Diagnosis was based especially on clinical criteria because joint fluid, blood and radiographs analyses and investigations were most of time impossible. The absence of these certain investigations reduced diagnostic precision and inevitably led to a few cases where no diagnosis could be made.

A therapeutic intervention was proposed to patients and often consisted in NSAIDs treatment, intra-articular steroid injection. Four patients on the 8 having an inflammatory joint disease were treated by hydroxychloroquine.

This is a very interesting study with a well-described methodology. This manuscript is clear, well-written and could be accepted for publication with only minor changes.

Minor comments

1. Authors said that MSK disorders, especially osteoarthritis, were more frequent in rural area than urban (52% versus 8% in Zambia). They explained that the most important reason for this difference was that older females were often responsible for much of manual work in rural Africa. Could other reasons be possible? Maybe, the use of effective analgesics and NSAIDs is easier in cities than in rural areas and perhaps patients consult less for pain in cities because they manage to relieve it themselves. Second, recourse to doctors is perhaps easier in the city than in the rural area. So we can assume that patients with pain may have consulted more in rural areas over this four-week study period than in towns.
2. Could the authors give the number of patients in each category in addition to the percentage? For example, for 8% of patients with MSK symptoms in Kabanana, this corresponds to how many patients.
3. In the tables, the abbreviations could be re-explained: CTS for example.