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Journal Name:	**Cardiology and Angiology: An International Journal**
Manuscript Number:	**2014_CA_10483**
Title of the Manuscript:	**Early or selective invasive strategy in patients with non-ST-segment elevation acute coronary syndrome according to the risk factors at presentation? An outcome study**
Type of the Article	**Original Research Article**

General guideline for Peer Review process:

This journal's peer review policy states that **NO** manuscript should be rejected only on the basis of '**lack of Novelty'**, provided the manuscript is scientifically robust and technically sound.
To know the complete guideline for Peer Review process, reviewers are requested to visit this link:

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PART 1: Review Comments

	Reviewer's comment	**Author's comment** *(if agreed with reviewer, correct the manuscript and highlight that part in the manuscript. It is mandatory that authors should write his/her feedback here)*
Compulsory REVISION comments	Thank you for the invitation. I have read the paper and have few comments to share with you: I congratulate the authors for their hard work and their review of the literature. Their research is definitely worth publishing in your journal. But before they get to this final step, there are few comments / questions that need to be answered or clarified for the readers. 1. There two similarly designed trials that tried to address the issue of Early Invasive versus Selectively Invasive Management for Acute Coronary Syndromes published in NEJM 2005 & 2009. Only the latter was referenced int his article despite the fact that both of them reached the same conclusion. I think it should be clearer that the current consensus about early intervention is NOT contradictory with regards to the general population of NSTE-ACS. 2. What was the method of randomization? (76 in the early invasive group and 102 in the delayed group)	

	3. There were only 28 patients with GRACE score > 140. What were the results for this sub-group with regards to the primary and secondary outcomes? 4. What were the criteria to refer the patients in the selective group to cardiac angiography? In the script, the authors stated that they were referred only if they had positive stress test (32 / 102) or recurrent angina? This need to be elaborated: clear definition of angina - how was it graded - angina despite medical therapy? Previous studies used the Canadian Society of Cardiology Classification or if the patients required recurrent admissions for chest pain evaluation as secondary end-points. 5. How can the authors explain the low number of PCI's in both group? How can they draw a conclusion with such a small number? Isn't the main point from early strategy is to rescue the ischemic myocardium with re-vascularization instead of medical therapy to prevent irreversible myocardial damage? Also time to intervention need to be cited for both groups in the table. 6. Please explain the relatively low levels of troponin in both groups?? The EKG criteria need to be clarified in the tables for both groups. Troponin was considered as one of the criteria for	

	early invasive strategy and advanced anti-thrombotic therapy as per the ACC/AHA guidelines. 7. How is this study different from the previous trials?? **[Comments received from mail]**	
Minor REVISION comments		
Optional/General comments		

Note: Anonymous Reviewer