

Dear editors,

Thank you for taking the time to review our manuscript. Please find below a point-by-point response to the comments we received.

A) The authors have carried out a large retrospective study using data from a well recognised database. The study is interesting but uses classification codes to identify obese patients and I suspect there data falls down on this basis. They have however, recognised this issue and discussed it in the paper. If the number of patients in the 'morbidly obese' group was higher then some of the inaccuracies of using this technique might have been ironed out but I suspect because the number in the target group was only 148 that this might not be the case. In addition the use of BMI as a categorical variable raises some concern as BMI is really a continuous variable and one wonders whether the role of a high BMI on transplant outcome would be more marked in this data set if it had been treated as such. Despite this the authors have noted these concerns in their discussion and the manuscript is well written and is deserving of publication provided that the potential flaws are clearly discussed.

- While we respect the editors concerns, the purpose of our study was specifically to study the outcome of liver transplantation in morbidly obese patients (BMI > 40). Therefore, we took into account BMI as a categorical variable, rather than a continuous. Moreover, due to small sample size of morbidly obese patients in our study sample, it's not possible to assess BMI in this group as a continuous variable.

B) 1) The retrospective study indicated that Morbid obesity might not impact in-hospital mortality and health care utilization in OLT recipients. But some collected information was dependent upon documentation of absence of pathology and stratification . The data didn't have data for re-admissions and long term outcomes of transplantation.

2) The conclusion is lack of generalizability due to these limitations.

3) I suggest that the data need further to be supplemented and analyzed.

- With respect to the editor, we have addressed these limitations in our discussion. The NIS data set is inherently dependent on documenting the presence or absence of pathology via ICD coding. In addition, NIS neither has information on re-admission nor long-term outcomes.

C) no comments

D) This is a very interesting study performed on a great US database based on more than 46.000 patients undergoing LT. The aim of the study is to investigate the role of morbid obesity as a risk factor after LT. The used statistical analyses are solid and appropriately chosen. The results are interesting. The study surely deserves to be published.

E) Morbid obesity is an important factor potentially influencing transplanted graft. Dr. Mumtaz et al. included 46,509 patients for this interesting study. Their findings revealed that morbid obesity may not impact in-hospital mortality and health care utilization in OLT recipients. However, morbidly obese patients may be selected after

careful assessment of co-morbidities. This will shed light on our clinical transplant practice. This study was well-designed and performed.

F) Khalid et al. performed nationwide surveillance of the outcomes of liver transplantation for morbid obesity patients. They found that the majority of post-transplant complications (except for EBL and respiratory complications) were equal between non-obese and obese patients, and there were no difference in mortality, LOS, or charges between the two groups. The authors finally concluded that in highly selected patients, morbid obesity may not be a significant contraindication to transplantation. This article has strong statistic power and is well-written. Minor comments; In Table 2 and Table 4, we think better to add morbidity of Clavien-Dindo classification ≥ 3 .

- The Clavien-Dindo classification is a system that includes how post-surgical complications are managed (i.e. need for repeat surgery, endoscopy, blood transfusions, etc.) Due to the nature of our database, we do not have the ability to obtain these variables, and therefore can not use the Clavien-Dindo morbidity classification in our paper.

Respectfully,

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