

**To: reviewer (code 02453621)**

Dear Sir/ madam,

Thank you for your time and comments! I appreciate it much.

**Comment 1:** The acronym of IR and ICR for incomplete revascularization have been mixed in use. Please unify the use of the term.

Reply: The corrections have been made and ICR now stands for incomplete revascularization throughout the paper.

**Comment 2:** . In Methods, the authors described the hand-search method that was used and previously validated. Since this method contribute a significant portion of the datasets, it is better to have a brief description for the method in this section for the sake of clarity to the readers.

Reply: We briefly described how we applied hand-search for our investigation in our revised manuscript.

**Comment 3:** There are a couple of places where the statistical significance within the >60 yo group was described (for example, mortality and MI). How about the <60 yo group? If it is not statistically significant, it would be better to describe for completeness.

Reply: We included a subgroup analysis for each of the analysed outcomes of mortality, MI, etc., namely mid term outcomes, long term outcomes and >60yo groups. In our study, data from table 2 and 3 show that only M G BOURASSA et al. recorded a mean age of <60yo for patients undergoing CR and ICR. The other nine papers recorded a mean age of >60yo which forms the basis for our subgroup analysis. Due to our study limitations, a meta-analysis of the <60yo subgroup is beyond the scope of this paper.

**Comment 4:** In page 9, MI, the authors described "Of the ten studies, seven reported MI and were used for this analysis. CR is associated with reduced rates of MI as compared to IR." Does this have anything to do with more prior MI in the ICR group (46.1% vs 39.8%)? Perhaps the difference between 46.1% and 39.8% is not significant. Is MI after ICR associated with prior MI in these cases?

Reply: In our study, we analysed the correlation between completeness of revascularization and post operative outcomes, one of these being the incidence of new-onset MI. Theoretically speaking, post-op new onset MI and previous MI located in the territory supplied by the same diseased coronary artery might have a strong correlation. However due to practical reasons, we have omitted cross-analysis of pre-op conditions

with post-op outcomes. According to our paper, post-operative MI is associated with the strategy of revascularization used (complete vs incomplete), and is not directly associated with previous pre-op MI.

**To: reviewer (code 03017516)**

Dear sir/ madam,

Thank you for your time and comments! I appreciate it much.

**Comment:** May you add quality evaluation and assessment of the risk of bias of the included studies?

Reply: So as to avoid the file drawer problem and publication bias, we refined our exclusion criteria. All the studies included in our study are either randomized controlled trials, observational studies, controlled clinical trials or clinical trials. Also, we excluded studies with small sample size (<100 patients). In the “methodological quality” section of our paper we assess quality and bias using namely the egger’s test, inverted funnel plots, etc.

Many thanks,

Best regards,

Merveesh. L. Auchoybur (author)