To

The Editor

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Thank you for considering our work for publication. We thank all the reviewers and editors for their useful comments. All the comments are well considered and we have modified the manuscript according to the suggestions. Please find below the answers to the reviewer's comments.

Reviewer 1

1. Abstract: please provide the full terminology for the acronym MELD
    a. Replaced with full term

2. Methods: probably there other comorbidities registered in the study but not cited in point D (variables analyzed) included in the Charlson index (e.g. peripheral arterial disease, etc.). Was the Charlson index modified to account for all subjects being affected by severe CLD?
    a. Other comorbidities which were not mentioned earlier are now added in the revised manuscript
    b. While calculating Charlson comorbidity index, patients with Child A disease were given a score of 1 (Mild), while those with Child B and C disease were given a score of 3 (moderate to severe) as per standard score.

3. Primary outcome: mortality and repeated admission represent competing risks; the author could consider to include a combined outcome of mortality/morbidity
    a. Added in table

4. Results: authors state that the presence of NCDs was related to STEMI; was some specific NCD associated to the presence of sepsis (possibly diabetes, etc.) or to the risk of AKI (e.g. chronic renal disease)?
    a. As already mentioned in table 4 (now table 5), NCDs were not associated with sepsis or AKI.

5. Figure 1: risk factors for mortality are represented hierarchically: is there a rationale for this choice?
    a. Based on the aOR, sepsis (6.5), AKI (2.69) and INR (1.75) were used in a hierarchical pattern.

6. Table 1: in the etiology of CLD, is "Non-B, Non-C" standing for unknown etiology?
    a. The term has been further clarified by using unknown etiology in parentheses.

7. Table 4: please provide in column headings number of subjects (NCDs Yes / NCDs No). Is the p-value obtained by the Fisher exact test (due to low numbers for NSTEMI)?
    a. Added number of subjects and percentage
    b. Yes, the p-value was obtained by Fisher exact test.
    c. This is now table 5

Reviewer 2

1. As in any association study, the predictive value of factors depends on the case mix and the selected items. In this case, it is mandatory to clarify the nature of the "decompensation" term. As an example, it is very difficult to imagine that GI bleeding was neither associated with morbidity nor with mortality. How many cases of GI bleeding were in the system? Was GI bleeding included as a putative variable, or only hemoglobin at admission was considered? This might explain why GI Bleeding was not a relevant factor.
    a. The term decompensation was already described in the section of MATERIAL AND METHODS under the heading of study design and settings as well as under heading of variable analyzed.
    b. GI bleeding was determined on the basis of the history of hematemesis or melena, rather than only hemoglobin at admission.

2. In this case, the authors should explain why they included AKI defined by a formula which is reasonable but might be changed and did not consider a very important morbidity as GI bleeding as a whole.
    a. Acute kidney injury (AKI) in our study was defined as per Kidney Disease: Improving Global Outcomes (KDIGO) Acute Kidney Injury Work Group, and revised consensus recommendations of the International Club of Ascites which are the most recent guidelines and have compared various definitions of AKI and given recommendations to follow this definition.

3. The finding that NCDs were not associated with mortality is not surprising. In the short-term – and 6 weeks are definitely a short term in the case of a chronic disease – no surprise that diabetes, hypertension (a rare event in cirrhosis), COPD did not affect mortality. Indeed, the only one which was more or less significant was NSTEMI.
    a. The short follow up has already been discussed under the heading of limitations.

Kind Regards

Shahab Abid