

Editor in Chief
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We are grateful to your and reviewers' insightful remarks and have provided the point-by-point responses hereunder.

Yours sincerely

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Comments to the authors – Reviewer 1

Abstract: replace “weight loss surgical procedures” with “bariatric procedures” - Abstract aim: morbidly obese patients, not “morbid obese patients” –

Done

Omit the technical details of sleeve gastrectomy and RYGB from the introduction as they are well known.

Done

It is unclear how remission of improvement in T2DM was defined in the articles reviewed or in the meta-analysis itself, please provide clear definitions.

Thanks for the comment. The same has been added in manuscript. The remission of T2DM was considered when HbA1c < 6.0 % or less without anti-diabetic therapy was achieved by bariatric procedures.

What was the time period for the search process (starting and end points).

The start and endpoints for the search was Jan 2013 to Jan 2018.

A recent review by Osland et al (cited as ref 18) reached similar conclusions to the present meta-analysis, the authors should emphasize the novelty of their review as compared to the previous one.

The systematic review by Osland et al. used RCTs only. In addition, the review has reported equal effectiveness of both LSG and LRYGB in resolving or improving preoperative type 2 diabetes in obese patients during the reported 3- to 5-year follow-up periods. However, our study used 6 original articles and 3 RCTs and reports a T2DM remission rate of 82.3% by LRYGB and 80.7% by LSG.

The main problem with the review is compiling RCTs and retrospective studies in one statistical analysis which may not be accurate.

Thanks for the comment. During the literature search of our systematic review and meta-analysis, a pre-post model was employed. We selected only those studies that compared the effectiveness of bariatric procedure in bringing the remission of T2DM. The selected RCTs and retrospective studies have fulfilled the selection criteria and the data retrieved from these reports was effectively and accurately used in the analysis.

Table 1 is overloaded, I suggest providing three tables, one for study characteristics, another for weight loss and improvement in comorbidities, and another for operation time, and complications.

Thanks for the comment. We have refined titles of the selected articles in Table 1. Its quite precise and condensed. In terms of comorbidities, operative time and complications, since this was not the primary or secondary outcome of this research, we cannot add this information as this will distract the readers from the main topic. The primary objective of this study is to compare the effectiveness of LSG and LRYGB for T2DM remission. We have already designed another study for the comparison of operative time and complications by LSG and LRYGB.

Reviewer 2

This is a good effort from authors. Agreed that we don't know if one procedure (sleeve vs bypass) is better than the other. Sleeve is a minimally invasive compare to bypass but post procedure complications (like leaks) are high with sleeve. It is interesting to know that diabetes is well controlled for 5 years but don't know if the patients regain weight or body adjusts to have a recurrence of diabetes.

Thanks for the appreciation of the subject. Agreed that LRYGB is more demanding, time consuming and challenging as compared to LSG. As already stressed in the article, the long-term

results of 10 years are still awaited and only then we can confer the effectiveness of these procedures for T2DM.

Well conducted study.

Thanks