

Reviewer #1:

Scientific Quality: Grade C (Good)

Language Quality: Grade B (Minor language polishing)

Conclusion: Minor revision

Specific Comments to Authors: This study compared the efficacy of BEC (143 patients) and AEC (137 patients) in maintaining reduction of manipulated DRFs. It has been found that the mean loss of RL, RI, VT were respectively 1,59 mm, 2,83°, 4,11° for BEC and 1,63 mm, 2,54°, 3,52° for AEC. The end treatment differences between BEC and AEC in RL, RI, VT loss were respectively 0,04 mm [CI 95%; -0.36;0.44], -0,29° [CI 95%; -1.03;0.45], 0,59° [CI 95%; -1.39;2.57] and they were all below the prefixed noninferiority thresholds. The rate of loss of reduction was similar. It concluded that BEC performs as well as AEC in maintaining the reduction of a manipulated DRF. Being it more comfortable to patients, BEC may be preferable for nonoperative treatment of DRFs. In general, this is an interesting study. It showed that short arm cast is equally effective as long arm cast to treat DRFs. However, there are a few concerns that need to be clarified:

POINTS OF CONCERNS – REVIEWER #1

1. Did the patients receive any closed traction and manual reduction before AEC and BEC, especially, for the type C and significant displacement type a and B? If so, did the patients receive any local anesthesia?

ANSWER: Yes, all patients received closed traction and manual reduction before cast immobilization. Furthermore, if adequate reduction could not be achieved, patient dropped out from study and was sent to surgical treatment. Only displaced fractures requiring manipulation were considered in this study since it is already well accepted that undisplaced fracture NOT requiring manipulation are adequately treated with below-elbow cast. *See subparagraph PROCEDURES, lines 4-5.*

Secondly, all patients received local anesthesia in the form of hematoma block. *See subparagraph PROCEDURES, lines 4-5.*

2. Had the cast ever been changed through the cast immobilization time? If not, how to prevent the cast immobilization failure?

ANSWER: The cast was made open for the first 5-7 days to allow room for swelling then was closed on day 7th. No further changes were made. The manufacture of cast was good enough to endure the full course of treatment. *See subparagraph PROCEDURES, line 12.*

Only eight patients had their cast damaged or broken during treatment (cast failure). All these patients dropped out from the study. Only patients who had their cast intact throughout the full course of treatment were considered for analysis. *See subparagraph Fig. 2, Study Flowchart.*

3. For the different subtype of the fractures, the wrists were casted in same position?

ANSWER: Yes, the forearm was immobilized in an opposite-to-dislocation position. That said, if the fracture was dorsally and radially displaced, cast was molded in a volar-flexion and ulnar-flexion fashion. *See subparagraph PROCEDURES, lines 5-6.*

(1) Science editor:

This clinical trial is interesting and within the scope of the journal. However, the authors are required to address ALL reviewers' comments before it can be re-reviewed. Indeed, although the authors have filled in a CONSORT statement in detail, some issues with reporting a clinical trial remain ie. discussion of dropouts, dropout rate, and how they would have affected the results of the study. Also, in parts, references are lacking, like in the methods section (page 2), where the outcome measures (X-ray examination parameters, DASH, SF-12) used are mentioned however without references Was intention-to-treat analysis performed, or were dropouts not taken into account? No academic misconduct is detected.

Language Quality: Grade B (Minor language polishing)

Scientific Quality: Grade C (Good)

ANSWER: References were added for X-ray examination parameters, DASH and SF-12.

Per-protocol analysis is a comparison of treatment groups that includes only those patients who completed the treatment originally allocated, while intention-to-treat analysis compares all patients recruited and divide them according to the treatment they were originally allocated. In noninferiority trials, both intention-to treat and per-protocol analysis are recommended [Shah PB. Intention-to-treat and per-protocol analysis. CMAJ. 2011;183(6):696. doi:10.1503/cmaj.111-2033].

In this specific trial, however, the dropouts did not depend on patients' compliance, such as in pharmacological studies, but mainly on acceptability of reduction, cast failure, or other reasons outside of patient's will and compliance, hence we did not consider them for final analysis (see fig. 2, study flowchart). When closed reduction is not deemed acceptable, the patient is no more eligible for cast treatment and he becomes candidate to surgical treatment. By including dropouts in the analysis, we would have attributed to both groups an effect derived from surgery and not from the type of cast assigned. This is the reason why, in this context, intention-to-treat analysis is not ideal. We thank the science editor for pointing this out and we added a brief clarification it in the materials and methods paragraph.

(2) *Company editor-in-chief:*

I have reviewed the Peer-Review Report, the full text of the manuscript, and the relevant ethics documents, all of which have met the basic publishing requirements of the World Journal of Orthopedics, and the manuscript is conditionally accepted. I have sent the manuscript to the author(s) for its revision according to the Peer-Review Report, Editorial Office's comments and the Criteria for Manuscript Revision by Authors. Before final acceptance, uniform presentation should be used for figures showing the same or similar contents; for example, "Figure 1 Pathological changes of atrophic gastritis after treatment. A: ...; B: ...; C: ...; D: ...; E: ...; F: ...; G: ...". Please provide the original figure documents. Please prepare and arrange the figures using PowerPoint to ensure that all graphs or arrows or text portions can be reprocessed by the editor. In order to respect and protect the author's intellectual property rights and prevent others from misappropriating figures without the author's authorization or abusing figures without indicating the source, we will indicate the author's copyright for figures originally generated by the author, and if the author has used a figure published elsewhere or that is copyrighted, the author needs to be authorized by the previous publisher or the copyright holder and/or indicate the reference source and copyrights. Please check and confirm whether the figures are original (i.e. generated de novo by the author(s) for this paper). If the picture is 'original', the author needs to add the following copyright information to the bottom right-hand side of the picture in PowerPoint (PPT): Copyright ©The Author(s) 2022. Authors are required to provide standard three-line tables, that is, only the top line, bottom line, and column line are displayed, while other table lines are hidden. The contents of each cell in the table should conform to the editing specifications, and the lines of each row or column of the table should be aligned. Do not use carriage returns or spaces to replace lines or vertical lines and do not segment cell content. Before final acceptance, when revising the manuscript, the author must supplement and improve the highlights of the latest cutting-edge research results, thereby further improving the content of the manuscript. To this end, authors are advised to apply a new tool, the RCA. RCA is an artificial intelligence technology-based open multidisciplinary citation analysis database. In it, upon obtaining search results from the keywords entered by the author, "Impact Index Per Article" under "Ranked by" should be selected to find the latest highlight articles, which can then be used to further improve an article under preparation/peer-review/revision. Please visit our RCA database for more information at: <https://www.referencecitationanalysis.com/>.