Point-to-point response

Reviewer #1: Thanks to all authors for such an effort. I have the following points:

1. Authors used the terms ACEi, ARBS, and RABs in the text and tables. For the reader, it seems they are using them interchangeably, although the numbers on the tables are different and not additive. It would be better to unify the terms in a group with a crystal-clear definition for easy readability, like (RAAS blockade). Terms and practice are not similar in all countries; thus, it would be better to use consensus terms.

Response: Thank you for your review and comments. We have now defined renin angiotensin system (RAS) blockers as encompassing angiotensin-converting enzyme inhibitors, angiotensin receptor blockers or renin inhibitors. We have now replaced the terminology 'RABs' to 'RAS blockers' throughout the updated manuscript, and in the tables and figures.

2. Authors emphasized the notion by most guidelines that NDCCBs are the preferred group of CCBs especially in. The results revealed that DCCBs are the 3rd option even in patients with proteinuria. This needs to be discussed. Is it deviation from the guidelines, why there is such a trend, and what are the possible factors?

Response: Thank you for your comment. We have now added in the discussion section that although non-dihydropyridine CCBs such as verapamil and diltiazem have been shown to reduce proteinuria to a greater extent compared to the dihydropyridine CCBs, prescribing non-dihydropyridine CCBs generally appear to be less popular in actual clinical practice, in contrary to guidelines, mainly due to concerns of increased risk of cardiac adverse effects such as bradycardia that could be potentially life-threatening in severe cases (see page 12 of manuscript file, with reference 26 to support this point).

3. Authors should mention that GFR analysis was not made to all participants as a limitation of the study.

Response: Thank you for your comment. We have now commented on this point in the revised manuscript – that there is incomplete data on determining the rate of decline in eGFR when comparing between CKD patients with three or more antihypertensive agents versus less than three antihypertensive agents prescribed,

due to delta eGFR data being unavailable for 162 patients, which is 5% of entire cohort (see page 14 of manuscript file).