

## ESPS PEER-REVIEW REPORT

**Name of journal:** World Journal of Diabetes

**ESPS manuscript NO:** 16063

**Title:** Treatment of prediabetes

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CLASSIFICATION	LANGUAGE EVALUATION	SCIENTIFIC MISCONDUCT	CONCLUSION
<input type="checkbox"/> Grade A: Excellent	<input type="checkbox"/> Grade A: Priority publishing	Google Search:	<input type="checkbox"/> Accept
<input type="checkbox"/> Grade B: Very good	<input type="checkbox"/> Grade B: Minor language polishing	<input type="checkbox"/> The same title	<input type="checkbox"/> High priority for publication
<input type="checkbox"/> Grade C: Good		<input type="checkbox"/> Duplicate publication	
<input type="checkbox"/> Grade D: Fair	<input type="checkbox"/> Grade C: A great deal of language polishing	<input type="checkbox"/> Plagiarism	<input type="checkbox"/> Rejection
<input type="checkbox"/> Grade E: Poor		<input type="checkbox"/> No	<input type="checkbox"/> Minor revision
	<input type="checkbox"/> Grade D: Rejected	BPG Search:	<input type="checkbox"/> Major revision
		<input type="checkbox"/> The same title	
		<input type="checkbox"/> Duplicate publication	
		<input type="checkbox"/> Plagiarism	
		<input type="checkbox"/> No	

## COMMENTS TO AUTHORS

In this manuscript Kanat et al. review the literature regarding prediabetes pathophysiology and discuss how progression from prediabetes to type 2 diabetes can be prevented. The paper is well written and of interest for both clinicians and researchers. Major comments: 1. There is much focus on IGT and less on IFG in the paper, although both prediabetic states are included in the term prediabetes. More emphasis on IFG and prevention of progression from IFG to diabetes would strengthen the paper. There is currently not evidence for effective prevention in IFG with lifestyle or weight loss, but this fact is more or less ignored in the review and IFG/IGT is often combined in the conclusions although only studies in individuals with IGT are cited (e.g. page 8 and page 21). A statement about which strategy will be most beneficial for prevention of type 2 diabetes in individuals with IFG is lacking. Metformin is currently recommended for both IFG and IGT (mentioned on page 9) although no clear evidence exists regarding its usefulness in preventing progression to diabetes in IFG. This could also be discussed in more detail. 2. HbA1c is now recommended for diagnosis of pre-diabetes and diabetes. Which implications do this have for the prevention of diabetes? The OGTT is seldom used in clinical practice and therefore IGT may not be

detected. This issue should be addressed. Minor comments: 3. Page 5: First-phase insulin secretion is also impaired during IVGTT in IFG (F?rch et al. Diabetologia 2008) 4. Page 5: Insulin resistance and beta cell function in IFG and IGT. See also F?rch et al. JCEM 2014. 5. Page 6: Intervention to prevent the progression of IGT to T2DM. See also Saito et al. Arch Inter Med 2011. 6. Page 6: Please add a reference to the following statement: "Weight loss, whether achieved via lifestyle modification, pharmacologic intervention or bariatric surgery, enhances insulin sensitivity, reduces the workload on the  $\beta$ -cells, and improves glucose tolerance in IGT individuals". 7. Page 11: Please add a reference to the following statement: "... although TZDs consistently have been at least twice as effective as metformin in reducing IGT conversion to T2DM". 8. Page 12: Please add a reference to the following statement: "GIP secretion is normal or slightly increased".