

**Manuscript ID:** 87473

**Title:** Knowledge, attitude, and practice of patients living with inflammatory bowel disease: a cross-sectional study

**Journal:** World Journal of Gastroenterology

## **Response to Reviewers' comments**

Dear Editor,

We thank you for your careful consideration of our manuscript. We appreciate your response and overall positive initial feedback and made modifications to improve the manuscript. After carefully reviewing the comments made by the Reviewers, we have modified the manuscript to improve the presentation of our results and their discussion, therefore providing a complete context for the research that may be of interest to your readers.

We hope that you will find the revised paper suitable for publication, and we look forward to contributing to your journal. Please do not hesitate to contact us with other questions or concerns regarding the manuscript.

Best regards,

## Reviewer #1

*The study is interesting with a significant element of originality, in the sense of the absence of related studies in China. The results showed a satisfactory level of KAP from the Chinese IBD patients although there were some limitations of the study as it was reported by the authors themselves. There are no particular remarks that could be made, but I would like the authors although they stated that "...Several studies revealed...", they do not refer extensively to these results. Therefore, I would like the results of these studies, especially those from developed countries, to be commented on more extensively in relation to the findings of the present study.*

**Response:** We thank the Reviewer for the comment. Several studies revealed misconceptions and relatively poor knowledge in patients with IBD about their disease [1-6]. A study from England published 30 years ago already acknowledged that patients with IBD had poor knowledge regarding their disease but were willing to acquire information [1]. More contemporary data indicated little progress since then, i.e., that the knowledge of patients with IBD toward their disease was poor [2-6], including in New Zealand [2], Canada [3], Israel [4], Poland [5], and South Korea [6]. Surprisingly, in the present study, the patients with IBD showed good KAP toward IBD, but it could be noted that most participants had a junior college/bachelor's degree and above education and were receiving expensive biological agents, thereby suggesting a higher socioeconomic status that could influence the results.

*Finally, although I assume that it was not included in the aims of the study if there were data regarding the course of the disease in patients with high and low KAP, to compare these groups to see if there were indeed differences that might be attributed to the level of KAR. This might be an objective and practical conclusion useful in daily clinical practice.*

**Response:** We thank the Reviewer. As shown in Table 1 and univariate analysis in Table 6, 7, 8, the duration of IBD was included in the study. Patients' knowledge (P=0.995), attitude (P=0.948), or practice (P=0.248) scores were not varied by their duration of IBD (Table 1), and univariate analysis showed that, the duration of IBD (<1 year and 1-2 years vs >2 years) of patients was not associated with high KAP scores (all P>0.05), indicating that the duration differences of IBD might not be attributed to the level of KAR.

## **Reviewer #2**

*Although other authors have studied the influence of knowledge on attitudes towards inflammatory bowel disease, the study shows locally how patients understand and act in relation to the disease and treatment. Knowing that knowledge is a factor in greater adherence makes clear the importance of the doctor in sharing information relevant to their illness with the patient. The study has local scope and the results cannot be extrapolated to other populations, which makes similar studies necessary in other locations.*

**Response:** We entirely agree with the Reviewer. We refined the related Limitation: “The questionnaire was designed by local investigators and was probably influenced by local policies and guidelines, further restricting the exportability of the questionnaire. The study has local scope, and the results cannot be extrapolated to other populations, which makes similar studies necessary in other locations.”

## Editorial Office

### 4 LANGUAGE POLISHING REQUIREMENTS FOR REVISED MANUSCRIPTS SUBMITTED BY AUTHORS WHO ARE NON-NATIVE SPEAKERS OF ENGLISH

*As the revision process results in changes to the content of the manuscript, language problems may exist in the revised manuscript. Thus, it is necessary to perform further language polishing that will ensure all grammatical, syntactical, formatting and other related errors be resolved, so that the revised manuscript will meet the publication requirement (Grade A).*

*Authors are requested to send their revised manuscript to a professional English language editing company or a native English-speaking expert to polish the manuscript further. When the authors submit the subsequent polished manuscript to us, they must provide a new language certificate along with the manuscript.*

*Once this step is completed, the manuscript will be quickly accepted and published online. Please visit the following website for the professional English language editing companies we recommend: <https://www.wjgnet.com/bpg/gerinfo/240>.*

**Response:** The manuscript was proofread.

### 5 ABBREVIATIONS

*In general, do not use non-standard abbreviations, unless they appear at least two times in the text preceding the first usage/definition. Certain commonly used abbreviations, such as DNA, RNA, HIV, LD50, PCR, HBV, ECG, WBC, RBC, CT, ESR, CSF, IgG, ELISA, PBS, ATP, EDTA, and mAb, do not need to be defined and can be used directly. The basic rules on abbreviations are provided here:*

*(1) Title: Abbreviations are not permitted. Please spell out any abbreviation in the title.*

**Response:** There were no abbreviations in the Title.

*(2) Running title: Abbreviations are permitted. Also, please shorten the running title to no more than 6 words.*

**Response:** There were abbreviations in the Running Title, and it contains five words.

*(3) Abstract: Abbreviations must be defined upon first appearance in the Abstract. Example 1: Hepatocellular carcinoma (HCC). Example 2: Helicobacter pylori (H. pylori).*

**Response:** The abbreviations are defined at first use.

*(4) Key Words: Abbreviations must be defined upon first appearance in the Key Words.*

**Response:** There are no abbreviations in the keywords.

*(5) Core Tip: Abbreviations must be defined upon first appearance in the Core Tip. Example 1: Hepatocellular carcinoma (HCC). Example 2: Helicobacter pylori (H. pylori)*

**Response:** The abbreviations are defined at first use.

(6) *Main Text: Abbreviations must be defined upon first appearance in the Main Text. Example 1: Hepatocellular carcinoma (HCC). Example 2: Helicobacter pylori (H. pylori)*

**Response:** The abbreviations are defined at first use.

(7) *Article Highlights: Abbreviations must be defined upon first appearance in the Article Highlights. Example 1: Hepatocellular carcinoma (HCC). Example 2: Helicobacter pylori (H. pylori)*

**Response:** The abbreviations are defined at first use.

(8) *Figures: Abbreviations are not allowed in the Figure title. For the Figure Legend text, abbreviations are allowed but must be defined upon first appearance in the text. Example 1: A: Hepatocellular carcinoma (HCC) biopsy sample; B: HCC-adjacent tissue sample. For any abbreviation that appears in the Figure itself but is not included in the Figure Legend textual description, it will be defined (separated by semicolons) at the end of the figure legend. Example 2: BMI: Body mass index; US: Ultrasound.*

**Response:** There are no figures in the manuscript..

(9) *Tables: Abbreviations are not allowed in the Table title. For the Table itself, please verify all abbreviations used in tables are defined (separated by semicolons) directly underneath the table. Example 1: BMI: Body mass index; US: Ultrasound.*

**Response:** All abbreviations are now defined as footnotes.

**Science editor**

The manuscript has been peer-reviewed, and it is ready for the first decision.

Language Quality: Grade A (Priority publishing)

Scientific Quality: Grade C (Good)

**Response:** We thank the Science Editor for the comments.

## **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 Gastroenterology, 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. Please 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.*

**Response:** The Tables were verified and comply with the requirements.

*However, the quality of the English language of the manuscript does not meet the requirements of the journal. Before final acceptance, the author(s) must provide the English Language Certificate issued by a professional English language editing company. Please visit the following website for the professional English language editing companies we recommend: <https://www.wjgnet.com/bpg/gerinfo/240>.*

**Response:** The manuscript was proofread.

*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 Reference Citation Analysis (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/>.*

**Response:** We made verifications, and all relevant papers are cited.

## References

1. Jones SC, Gallacher B, Lobo AJ, Axon AT. A patient knowledge questionnaire in inflammatory bowel disease. *J Clin Gastroenterol.* 1993;17(1):21-4.
2. Buerkle KS, Vernon-Roberts A, Ho C, Schultz M, Day AS. A Short Knowledge Assessment Tool Is Valid and Acceptable for Adults with Inflammatory Bowel Disease. *Dig Dis Sci.* 2022;67(6):2049-58.
3. Benchimol EI, Walters TD, Kaufman M, Frost K, Fiedler K, China Z, et al. Assessment of knowledge in adolescents with inflammatory bowel disease using a novel transition tool. *Inflamm Bowel Dis.* 2011;17(5):1131-7.
4. Krauthammer A, Harel T, Zevit N, Shouval DS, Shamir R, Weiss B. Knowledge of disease and self-management of adolescents with inflammatory bowel diseases. *Acta Paediatr.* 2020;109(10):2119-24.
5. Kowalska-Duplaga K, Gawlik-Scislo A, Krzesiek E, Jarocka-Cyrta E, Lazowska-Przeorek I, Duplaga M, et al. Determinants of disease-specific knowledge among children with inflammatory bowel disease and their parents: A multicentre study. *World J Gastroenterol.* 2021;27(27):4468-80.
6. Kim JY, Yoon H, Hwang JS, Yang SK, Park SH, Loftus EV, Jr. Comparison of Disease-related Knowledge of Patients With Inflammatory Bowel Disease Between the West and the East Using an Updated Questionnaire (IBD-KNOW). *J Clin Gastroenterol.* 2020;54(8):720-4.