68536-Answering Reviewers.

Specific Comments to Authors: In this manuscript, the authors investigated the incidence of T2DM among GDM patients (9 years of follow-up period).

1) **"Introduction" could be shortened.**

The Introduction has been shortened from 997 words to 619 words.

2) **What are cut-off values of FPG and/or 2h PPG for the development of T2D from GDM?**

A new section in Methods has been added [***Specificity and Sensitivity of FBG and 2hrBG in Predicting T2D*]**. The best cut off values for FBG for predicting T2D from GDM were calculated using the Youden Index: [(sensitivity + specificity) -1]. In the Results Section the cut off value of FBG ≥ 103 mg/dl in 2007, above which T2D was diagnosed in 2016; was identified. However, on testing the 2hrBG level in 2016, only five subjects were classified as T2D. Analysis to find the best cut off value for 2hrBG was, therefore, not feasible.

3) **The authors concluded that both FPG and 2h PPG at diagnosis of GDM can predict future development of T2DM. However, specificity is lacking.**

In the new section in Methods [*Specificity and Sensitivity of FBG and 2hrBG in Predicting T2D*], we describe how we used the open source R-4.02 statistical software to plot the Receiver Operating Characteristic (ROC) curve for the OGTT. The FBG and 2hrBG levels in 2007 have been categorised as GDM/Normal subjects. The diagnosis of T2D/Normal in 2016 was considered as Gold Standard (GS) using Hb A1C levels. The diagnosis of T2D was confirmed by correlation of FBG and 2hrBG values with Hb_{A1C} levels (Pearson correlation at 0.798; $p \leq 0.01$). In order to find the best cut off values for 2007 FBG, the actual values were plotted against the GS results (T2D or Normal). At each cut off value of the 2007 FBG level, the sensitivity and specificity were calculated by forming a 2 by 2 table with the GS results (Table 5).

4) Novelty of this manuscript should be clarified because it is well-established that GDM is high risk for T2DM.

We are not questioning that GDM is high risk for T2D. We are attempting to apply the new knowledge on the subtyping of both GDM and T2D with prediction of T2D following GDM. Our results show that women who convert to T2D have raised FBG due to peripheral resistance to the action of insulin, compared to those with raised postprandial 2hrBG levels who suffer insulin secretion defects. Postnatal management like frequent follow-ups, lifestyle modifications, and specific

treatment protocols, could be highly successful in slowing down the development of T2D in the former group of women. This is bringing the idea of personalized care closer, as pathophysiology is used to distinguish subtypes from each other.

5 Abbreviations:

(1) Title: The Title have been modified. No abbreviations are used.

(2) Running title: Shortened to 6 words.

(3) Abstract: No change

(4) Key words: Five Words with abbreviations defined upon first appearance

(5) Core tip: No change

(6) Tables: Verified abbreviations.

6. Citations:

Old citations were removed. New Published work has been cited. The number of citations decreased from 40 down to 36.

7. Conflict-of-Interest Disclosure Form:

Form is added to submission.

8. Copyright License Agreement:

Form is added to submission.

9. Author Contribution Section:

Section is added to submission.

10. Funding Agency.

Document copy provided

11. The "Article Highlights" section:

Section is added to submission.