Author’s response to reviews

Title: Abstract analysis method facilitates filtering low-methodological quality and high-bias risk systematic reviews on psoriasis interventions

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Author’s response to reviews:

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Andrea Catherine Tricco, PhD
Associate Editor
BMC Medical Research Methodology

Dear Dr. Tricco:

Thank you for agreeing to consider reviewing a revised version of manuscript BMRM-D-17-00281 entitled "Abstract analysis method facilitates filtering low methodological quality and
high bias risk systematic reviews concerning psoriasis interventions" for publication in the BMC Medical Research Methodology journal.

We thank the reviewers for their constructive comments that have helped us to greatly improve the manuscript. Below, we address all of the reviewers’ comments point-by-point and present our subsequent modifications.

On behalf of all co-authors,

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Reviewer 1

Dawid Pieper, MPH

Q1: Please be more specific about the audience of this article. Do you think your method could be applied in the process of an overview (Review of Reviews)? Or is it more appropriate for busy clinicians when searching quick and dirty for a SR? In the first case, I think the loss of relevant papers might be too high in the light of your decision tree rules.

R1: We wholeheartedly agree with the reviewer’s comments. Our proposal is aimed to facilitate the evaluation of evidence synthesis documents by clinicians (physicians, pharmacists, managers). A clear problem that exists is that the amount of clinical problems to afford in clinical practice is increasing and the time to solve them is limited. A lack of knowledge and skills in the methodological evaluation of synthesis by clinical professionals adds the enormous increase in the documents generated in recent years, which in many cases associate a low methodological quality and even showing different answers to the same question.

In any case, we are aware that our method could be improved, since the rate of misclassification is 20%, which could lead to loss of relevant documents. For this reason, we believe that there is room for improvement, both in the quality of reporting by SRs generators and the method of classification we propose. We have included a paragraph in the Conclusions section as it follows (pg 7, ln 25-33):
“Our proposal is aimed to facilitate the evaluation of evidence synthesis by clinical professionals with a lack of methodological knowledge and skills. It does not intend to replace the rigorous final analysis of each review, but it allows to prioritize in a simple and rapid way those documents obtained in a first search. We believe that summaries are a good source to investigate methodological quality and risk of bias through quality and completeness assessment of abstracts. We are aware that our decision trees could be improved and that a external validation of our models in different research fields is necessary.”

Q2: Furthermore, it is not clear what was the basis for your decision tree rules? How did you derive the cut off points (eg 6 as shown in figure 4). If there is not a clear rationale for this why not perform (at least) sensitivity analyses in order to find an optimal cut-off point. Such an analysis would also allow to make the results suitable to more than one audience Group (ie. systematic reviewers that do not want to miss too much relevant studies and busy clinicians).

R2: Decision trees were obtained using the rpart R package that implements several algorithms. Cut off points were obtained as results of complex internal processes of these algorithms, and therefore they were not selected by the authors.

Summarizing, every tree is made up of decision nodes, branches and leaf nodes. The tree is placed upside down, so the root is at the top and leaves indicating an outcome category is put at the bottom. At the root, all classifications are mixed, representing the original dataset. Then the tree grows to the first node where a certain feature variable is used to split the population into categories. Because the parent population can be split into in numerous patterns, we are interested in the one with the greatest purity. In technical terminology, purity can be described by entropy. Statistics such as Gini index, Chi-square statistics, and gain ratio are employed to describe the purity and to optimize the tree by selecting the best splitting.

In our case, 'total_score' is a categorical variable with 12 levels (from '1' to '12'), and the rest of variables are binomial ('0' or '1'). The sample is successively split so as to build a highly detailed tree. The splitting process is stop when: a) The node is 'pure', thats it means containing only one category of the output values; b) the number of output values in the node is less than a fixed size. This node is the declared terminal node or leaf; c) The maximal tree is very large (called pruning process, removing the large branches that provide the least information). From the obtained sequence of subtrees, the optimal tree is selected by cross-validation and pruning-sample methods.

We used cross-validation method to evaluate predictive accuracy of our model as compared with the rest of tree models. In our case, models differ in nodes features, and therefore their cutting point. Finally, we selected the model with the lowest misclassification rate.

As reviewer suggested, we have performed “a sensitivity analysis for both AMSTAR and ROBIS classification trees by random selection of the training dataset to build 2.000 models in each case. Values of 'variable importance' parameter obtained for every node and model were plotted” (pg 4, In 28-33).
Supplementary graphs S3 and S4 show sensitivity analyses for both PRISMA-A based classification trees. Jitted variable importance values per node were plotted after n=2,000 random models were built in each case.

“We found that the nodes included in our tree models were also at the top ranking of nodes when ordered by median importance after sensitivity analysis. Overall, a higher dispersion of 'variable importance' values of AMSTAR-derived trees as compared with ROBIS trees suggests that AMSTAR classification tree is less robust than ROBIS classification tree”. (pg 6, ln 1-7).

Q3: However, thinking of busy clinicians as the target audience of this Analysis, I am concerned about the applicability as I think most of clinicians for whom your decision tree rule might be helpful are probably not aware of PRISMA-A at all. Please discuss more on the applicability of your findings.

R3: Thank you for the helpful suggestion. As mentioned before, the production of secondary research has grown exponentially, but although it is usually published through peer review, they do not currently incorporate the measure of their quality or their risk of bias by any of the available tools. Being able to choose the most valid reviews in the shortest possible time is a fundamental requirement in the clinical field. However, in most cases, clinicians do not have the necessary methodological knowledge or time to apply them. Probably the spread of the use of evidence-based medicine will lead to greater training in decision-making. Our spirit is helping to simplify this process. Abstracts, title and plain language summaries are often the first, and sometimes the only point of contact between readers and systematic reviews. On the other hand, in our opinion PRISMA for Abstracts requires less methodological knowledge than AMSTAR and its application also requires less time.

We have included a paragraph coming all these features in the 'limitations subsection' at the manuscript's Discussion section as it follows (pg 7, ln 1-10):

“Our decision tree has been constructed using a machine learning tool. This type of technology is currently being used to systematize some aspects of RS such as article selection or risk assessment bias[8]. We believe that the association of validated tools that measure quality or bias risk and machine learning technology may improve methodological assessment processes. Better meta-epidemiological knowledge together with the development of text mining strategies will allow to develop models that help clinicians to simplify making decisions at clinical setting.”.

Q4: Another point of concern is that you seemed to have change your Primary Outcome. According to PROSPERO your Primary Outcome was "To compare AMSTAR and ROBIS tool for the assessment of the quality of systematic reviews published on Psoriasis". I did not found this comparison in your manuscript all. There are also subgroup analyses mentioned in PROSPERO that are not included in the paper. Your Statement "We did not add, omit, or change outcomes after our protocol was published" is misleading, in my opinion.

R4: We agree with the reviewer’s comment. Indeed, we have previously performed the proposed analysis but the results had been included in a different article recently published (F. Gomez-Garcia, J. Ruano, J. Gay-Mimbrera, M. Aguilar-Luque, J.L. Sanz-Cabanillas, P. Alcalde-
Mellado, B. Maestre-López, P. J. Carmona-Fernandez, M. Gonzalez-Padilla, A. Vélez García-Nieto, B. Isla-Tejera. Most systematic reviews of high methodological quality on psoriasis interventions are classified as high risk of bias using ROBIS tool. J Clin Epidemiol. 2017 Sep 8. pii: S0895-4356(17)30534-6. doi: 10.1016/j.jclinepi.2017.08.015. [Epub ahead of print]) and that was under review while the present manuscript was being assessed. For this reason, we did neither included those data nor made any reference to the article under review.

Overall, our results suggest that methodological quality only explains a proportion of the bias risk of SRs, as we observed that most of reviews classified as high and moderate methodological quality by AMSTAR were also considered as displaying a high risk of bias using ROBIS (Table 2, Figure 3c, Figure 4, and Figure S3 of the above mentioned article).

As suggested, we have deleted the sentence “We did not add, omit, or change outcomes after our protocol was published” and included two new brief paragraphs at the Method section as it follows:

-“To begin, we established an a priori protocol to evaluate AMSTAR vs ROBIS in which we predict the measurement of compliance with PRISMA-A and published it in the PROSPERO International Prospective Register of Systematic Reviews (PROSPERO 2016: CRD42016053181).” (pg 3, ln 47-52).

-“We decided to use the machine learning classification procedure to obtain classification trees based on PRISMA-A after our protocol was published.”(pg 4, ln 40-42).

Q5: It is an important Limitation that the authors calculated sum scores for AMSTAR and PRISMA-A. By doing so, each item receives the same weight. This is a practical and understandable choice but it is clear Limitation as both AMSTAR and PRISMA-A were not developed to obtain sum scores.


It is well known that for the evaluation of the quality and risk of bias tools are currently preferred that are structured in domains vs. those consisting of scales or checklists. One of the reasons for this is that it is doubtful whether the actual weight of each item is the same for each of them. An example of this is the Cochrane tool for risk assessment of bias or the ROBIS tool. Although AMSTAR is the most universally accepted quality assessment tool, one of the most criticized features is that there is no guidance on how to translate the total score into categorical ratings.
However, in the literature the sum or percentage of items has been used to measure the quality of the report, and in our case, map reducing allowed us to simplify tagging reviews to perform more sophisticated analyses.

Q6: Furthermore, the authors categorized AMSTAR score to come up with high, moderate and low methodological Quality. What are the cut points for this categorization.

R6: Most of studies establish quality levels using similar cutoff points for low (0-3), moderate (4-7), and high (8-11) methodological quality, respectively. We have been stricter in distinguishing between high quality SRs from moderate and low reviews. In the literature, either the sum of scores or the percentage of items has been used to measure the overall methodological quality of reviews (Zarin W, Veroniki AA, Ninci V, et al. Characteristics and knowledge synthesis approach for 456 network meta-analyses: a scoping review. BMC Med. 2017; 15: 3.)

To clarify this point, we have added the following paragraph at the Method section of the manuscript (pg 4-5, ln 52-53, 1-2): “Review quality was classified by AMSTAR score following quality levels with similar cutoff points used by most of studies [for low (0-4), moderate (5-8), and high methodological quality (9-11) respectively].”

Q7: For ROBIS, I am wondering that there is no SR that was rated to have an unclear risk of bias. This needs some explanation as this seems very unlikely to me. Or did the authors only categorize into high and low risk of bias?

R7: We followed the evaluation instructions with ROBIS (http://www.bristol.ac.uk/media-library/sites/social-community-medicine/robis/robisguidancedocument.pdf accessed 5 sept 2017) as outlined in the user guide of this tool. Some of the SRs that were discussed and that needed a third evaluator presented a risk of uncertain bias. In these cases the final decision to include them in the group of high or low risk bias was taken by a third researcher. By reducing ROBIS levels, classification tree analysis was performed without losing statistical power.

To clarify this issue, we have added the following paragraph at the Method section of the manuscript (pg 4, ln 23-27): “To simplify analyses, SR that we rated to have an unclear risk of bias using ROBIS tool were discussed with a third evaluator to take the final decision to categorize them in the group of high or low risk bias”.

Q8: PRISMA-P is mentioned several times in the manuscript. Should this read PRISMA-A? Please check. PRISMA-P is for protocols of SRs.

R8: This must be a confusion, thank you for pointing it out. We have changed “PRISMA-P” for “PRISMA-A” in the new version of the manuscript.

Q9: I am not sure where the first part of the references stem from. The authors cite reference 14, but this is about Depression and not psoriasis.

R9: Despite to be an paper about depression, the conclusions about the authors found a positive correlation between AMSTAR and PRISMA-A scores, as we did. Furthermore, we have included

Q10: There might be differences in the results depending on publication year (before vs. after publication of PRISMA-A). A subgroup Analysis must be included for this reason.

R10: As suggested, we have performed a new regression analysis considering reviews classified as they were published before (n=71) and after (n=68) the PRISMA-A statement paper (Beller EM, Glasziou PP, Altman DG, et al. PRISMA for Abstracts: Reporting Systematic Reviews in Journal and Conference Abstracts. PLoS Medicine. 2013;10(4):e1001419. doi:10.1371/journal.pmed.1001419). We did not found this new variable as predictor of PRISMA-A results. We have included this data at the Method section (pg 4, ln 3-4) and in table 2 of a new version of the paper.

Q11: I was also missing Information on publication years in the manuscript.

R11: Included reviews were published from 1997 to 2017 as the following table shows. This info has been included at the Results section of the manuscript: “Thus, 139 reviews comprising 4,357 primary studies about interventions in psoriasis were published by 62 journals from 1997 to 2017.” (pg 5, ln 6).

1997: 1
1999: 1
2000: 2
2001: 3
2002: 2
2003: 1
2006: 5
2008: 2
2009: 5
2010: 1
2011: 8
2012: 19
Q12: Different reviewers applied PRISMA, AMSTAR and ROBIS. Please discuss whether this might have an influence on your results as there is some evidence that such Ratings much be dependent on the reviewers (i.e. they vary much depending on who is going to perform the assessment). Therefore, I think it would be interesting to state the inter-rater reliability for each Instrument (this was also mentioned in the protocol). And I would also be interested to see the results of inter-rater reliability at the item-Level. Consider providing this is supplementary material. I would expect much variability in applying PRISMA-A. This is also supported by comparing the Binga et al. with the Tsou & Treadwell study. The latter showed much higher scores that the Tsou study. The difference outweights the smaller differences in time in the Binga et al. Study.

R12: The inter-rater reliability obtained by our group for both AMSTAR and ROBIS have been published recently (F. Gomez-Garcia, J. Ruano, J. Gay-Mimbrera, M. Aguilar-Luque, J.L. Sanz-Cabanillas, P. Alcalde-Mellado, B. Maestre-López, P. J. Carmona-Fernandez, M. Gonzalez-Padilla, A. Vélez Garcéa-Nieto, B. Isla-Tejera. Most systematic reviews of high methodological quality on psoriasis interventions are classified as high risk of bias using ROBIS tool. J Clin Epidemiol. 2017 Sep 8. pii: S0895-4356(17)30534-6. doi: 10.1016/j.jclinepi.2017.08.015. [Epub ahead of print]). Assessment of the methodological quality using AMSTAR questions began after agreement among reviewers was substantial (Fleiss' kappa (κ) = 0.75; 95% CI, 0.69-0.82). Two investigators (FG-G, and MA-L) independently assessed ROBIS. When the risk of bias was assessed using ROBIS, the percentage of rater agreement was lower than what was observed with AMSTAR rater agreement (kappa = 0.70; 95% CI, 0.66-0.81). Researchers who assessed AMSTAR were FG-G and JG-M instead of PA-D and BM-L as it appears erroneously in the manuscript. This confusion has been fixed in the new version of the paper.

As suggested, we have calculated interrater reliability (IRR) for PRISMA-A. The median κ was substantial (κ = 0.77; 95% CI, 0.59-0.88). IRR was highest for question PEA1 (κ = 0.86) and lowest for question PEA8 (κ = 0.08). A table with these results has been included as Supplementary Material in the new version of the manuscript (Additional file 7). Raw data and R code for calculations have been uploaded to our GitHub repository. Our median IRR was higher for ROBIS as compared with κ recently found by Bühn et al (Bühn S, Mathes T, Prengel P, Wegewitz U, Ostermann T, Robens S, Pieper D. The risk of bias in systematic reviews tool showed fair reliability and good construct validity. J Clin Epidemiol. 2017 Jul 8. pii: S0895-4356(16)30672-2. doi: 10.1016/j.jclinepi.2017.06.019.). They found a lower kappa value with a wider range, probably due to: 1) we did performed informative and training meetings to raters
before starting the evaluation with PRISMA-A; 2) a different number of reviews analysed in our case (n=139 vs n=16).

As suggested, we have included the following paragraph at the Discussion section of the manuscript (pg 6, ln 41-47): “A limitation of this work is that different reviewers applied PRISMA, AMSTAR and ROBIS. Only one of three raters carried out the evaluations both with AMSTAR and ROBIS tools. Although their results were compared in pairs and discrepancies were discussed with a fourth rater, there is a risk that this issue will affect the validity of our results.”

Some of the influencing factors needs more explanation. For example, …

Q13: what is meant with 8-headings abstract format?

R13: The “8-headings abstract” format include: background, objectives, search methods, selection criteria, data collection, analysis, main results, and author's conclusions. This definition has been included at the Method section of the paper (pg 4, ln 6-9).

Q14: What is meant with Cochrane Affiliation?

R14: “Cochrane Affiliation” are those reviews conducted by authors within the Cochrane (Collaboration). This definition has been included at the Method section of the paper (pg 4, ln 33-36).

Q15: How did you investigate whether the Journal is endorsing PRISMA? Please be aware that checking this in the authors instructions today does not mean whether this was also the case in the year when the manuscript was submitted to the Journal.

R15: We checked the list of journals endorsing PRISMA at the PRISMA web (URL: http://www.prisma-statement.org/Endorsement/PRISMAEndorsers.aspx). However, as the reviewer mentions, it is a limitation not to have considered the year in which journals are endorsing PRISMA-A and there is a risk of bias in this regard. For this reason, we will include the following comment as a limitation of the study in the Discussion section of the new version: “It is a limitation not to have considered the year in which journals are endorsing PRISMA-A and there is a risk of bias in this regard.” (pg 6, ln 47-50).

Q16: It would also be worth knowing how many Journals were included in total. Are the IF from one year of from the corresponding year of publication?

Q16: A total of 139 reviews published in 62 journals were analysed. IFs were obtained from JCR taking into account the year in which the review was published. These features will be clarified at the Method and the Results sections of the new manuscript.

Q17: The methodological section needs to elaborate on how do you derive your multivariate analysis.
R17: We have now described better the multivariate analysis at the Methodological section in a new version of the manuscript. With this purpose, a new paragraph has been included in the new version of the paper as follow (pg 4, ln 13-15): “Multivariate predictive model was created including those variables that were statistically significant in the univariate predictive models (p<0.05).”

Q18: Furthermore, is there Explanation you could think of why academic source of finding seems to be an important predictor?

R18: As we have observed in this study, abstract quality and completeness (PRISMA-A) and methodological quality (AMSTAR) of SRs are related. Our group has previously demonstrated that methodological quality of SRs using AMSTAR may be predicted by several factors, among which are the source of funding (Gómez-García F, Ruano J, Aguilar-Luque M, Gay-Mimbrera J, Maestre-Lopez B, Sanz-Cabanillas JL, Carmona-Fernández PJ, González-Padilla M, Vélez García-Nieto A, Isla-Tejera B. Systematic reviews and meta-analyses on psoriasis: role of funding sources, conflict of interest and bibliometric indices as predictors of methodological quality. Br J Dermatol. 2017 Jun;176(6):1633-164). In our opinion, the above mentioned results may reflect such an indirect relationship.

Q19: In the implications of results section it is stated "the final classification determined in both decision trees is congruent with the idea that methodological quality explains only part of the risk bias of SRs", while you conclude that "that the methodological quality and the risk of bias of SRs may be captured by analysing the quality and completeness of abstract reporting, and that by applying our decision tree models, the review-filtering process may be improved through rapid abstract Analysis". This seems somehow contradictory to me. Maybe I am missing something, but I cannot follow this conclusion, while I agree with the first sentence (... that it can only be explained in part).

R19: We have employed the concepts of risk of bias (RoB) and methodological quality included in the Cochrane Handbook. In this sense “The ‘assessment of methodological quality’ suggests an investigation of the extent to which study authors conducted their research to the highest possible standards. This would be different from the RoB, or risk a systematic error in conducting the study”. It is therefore plausible that the results of AMSTAR do not correspond to those of ROBIS as we have recently demonstrated (Gomez-Garcia, J. Ruano, J. Gay-Mimbrera, M. Aguilar-Luque, J.L. Sanz-Cabanillas, P. Alcalde-Mellado, B. Maestre-López, P. J. Carmona-Fernandez, M. Gonzalez-Padilla, A. Vélez García-Nieto, B. Isla-Tejera. Most systematic reviews of high methodological quality on psoriasis interventions are classified as high risk of bias using ROBIS tool. J Clin Epidemiol. 2017 Sep 8. pii: S0895-4356(17)30534-6. doi: 10.1016/j.jclinepi.2017.08.015. [Epub ahead of print]). Even more so because in ROBIS does not only evaluate methodological compliance but the authors' interpretation of the limitations of their work. In our opinion, these results support that there are differences between the concepts of methodological quality and risk of bias. The methodological quality explains only part of the risk of bias of SRs. Given that we have validated tools that measure methodological quality and RoB, we have both faced PRISMA-A finding that the decision tree can independently extract both evaluations.
Q20: In the same context, please also check your conclusions section. The conclusion seems to be too strong in the light of your results. Consider diluting.

R20: We appreciated this comment very much. As suggested, we have change the Conclusions as it follows (pg 7, ln 25-36): “Our proposal is aimed to facilitate the evaluation of evidence synthesis by clinical professionals with a lack of methodological knowledge and skills. It does not intend to replace the rigorous final analysis of each review, but it allows to prioritize in a simple and rapid way those documents obtained in a first search. We believe that summaries are a good source to investigate methodological quality and risk of bias through quality and completeness assessment of abstracts. We are aware that our decision trees could be improved and that a external validation of our models in different research fields is necessary.”

Reviewer 2

Woo Jong Shin

Q1: The author used AMSTAR and ROBIS as a quality assessment tool to assess a systematic review and meta analysis. AMSTAR is a uniformly accepted and has a validation. Regarding to ROBIS, the author did not introduced proper reference about ROBIS. Please introduce a adequate reference of ROBIS.

R1: As suggested, three new references has been included in a new version of the manuscript:


Q2: The author described about the limitation of the generalisability of this data because the topic of systematic review is confined to the disease of psoriasis. But they suggested and proposed to use two decision trees to evaluate the quality of systematic review as if the topic of the reviews were not confined to the specific disease. These might cause confusion to the readers. Please mention and describe about the limitation of these data.
R2: It is a very interesting appreciation on the part of the reviewer. Our aims is to explore a new approach to help clinicians to perform quality and risk of bias assessment review filtering through rapid abstract evaluation. For this purpose, we performed PRISMA-A assessment of a high number of reviews about psoriasis that have been previously evaluated using AMSTAR and ROBIS tools. We consider that multiscale data and metadata is a strength of our study, although there still are some limitations as reviewer highlights. We have included a paragraph at the Discussion section related with this issue (pg 6, ln 22).

Q3: Reference number 4, 8, 12, 14 should be rechecked and revised.

R3: Thank you very much for point this out. We have solved these errors in the new version of the manuscript as it follows:


Reference #14 (Rice DB, Kloda LA, Shrier I, Thombs BD. Reporting quality in abstracts of meta-analyses of depression screening tool accuracy: a review of systematic reviews and meta-analyses. BMJ Open 2016;6:e012867). We have checked the cite ans it is ok. As we have explained above to reviewer #1 (Q9), despite to be an paper about depression, the conclusions about the authors found a positive correlation between AMSTAR and PRISMA-A scores, as we did.

Q4: Page 6 of 9 (line 11, 14)
R4: As suggested, the mentioned subsection title and following paragraph have been modified to improve their meaning.

The old version...

[“Limitations and strengths

In this study, we explored, for the first time, the capacity of PRISMA-A to determine both the methodological quality and the bias risk of full-text reviews measured using ROBIS and AMSTAR tools.”]

has been replaced by this one...

[“Strengths and limitations

In this study, we explored for the first time the capacity of PRISMA-A to determine both the methodological quality and the bias risk of full-text reviews using ROBIS and AMSTAR tools.”](pg 6, ln 4-8).

...Q5: Appendix 1 (MSeH)

R5: The expression “MSeH terms” has been replaced by “MeSH terms” in the new version of the Appendix 1. Thank you for pointing it out.

Finally, we would like to thank both reviewers and editor for their insightful comments, and for your very and careful review of our paper. After completion of the suggested edits, the revised manuscript has tremendously benefitted from an improvement in the overall clarity of the presentation.