Author’s response to reviews

Title: Factors for successful weight loss after bariatric surgery. Are there really any predictive factors for a successful weight loss after bariatric surgery? : Results from a group of severely obese patients

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Answers to reviewer reports (2)

Mauro Lombardo (Reviewer 1):
The review of the paper has made it more readable and interesting. However, many points remain unclear.

The assessment of nutrition in subjects is not standardized. The 24-hour recall in super obese patients is certainly not reliable.

We agree. Indeed, 24-hour recalls have several disadvantages that have been tried to be solved using standard questionnaires such as the food frequency questionnaire. Unfortunately, these methods require thorough standardization and adaptation to different languages and populations and they are not yet available for our country. Some studies suggest that associations with dietary quality are highly dependent on the diet score used, and less dependent on the method of dietary assessment. (Mertens J, et al. Nutr J. 2019; 18: 2.) The 24-hour recall was the only tool available for us at the time to have an approximation of the consumption of kCal and macronutrients that the patients had after the surgical procedure. We consider the fact that all patients were evaluated using the same strategy, the differences between them are relevant even when the absolute number of the amount of kcal consumed, the g of protein, carbohydrates and lipids may not be
comparable to other populations; these issues were specified in the discussion section (Line 310-321).

The differences between the two groups are not well explained. The results shown are poor and confusing.
We were also baffled by the finding of little differences between both groups. We discussed this at length and determined that:

1) This is a very homogeneous group with severely obese patients, with a large number of them ranging in the super or super super obesity. It is not habitual to have such a large proportion of patients in these categories, since some studies report results with patients that range from grade II to the lower ranges of grade III obesity. It is well known that very homogeneous groups tend to show smaller differences or none at all. We consider that a larger group of patients in these categories or longer follow ups may be necessary to detect differences. We also consider that may be, these patients will require their own criteria for evaluation.

2) One must remember that a lot of the data shown reflects the patients’ status at the initial evaluation. Not finding differences at baseline is indicative of the fact that the clinical and biochemical characteristics of these patients are not enough to determine future success of the surgery. We consider that economic, social, cultural and psychological characteristics of our population may also be influencing the end result, but since these aspects are not part of the aim of the study, they were not evaluated.

We have tried to explain these results more thoroughly. We believe that the results are significant because, as we explain in the manuscript, our strength lays in the strict criteria used considering that there are still no guidelines to define these variables after bariatric surgery. Besides the difference in current age and age at the time of surgery (being older or <50 y for the non-successful group, respectively), the type of surgery was a highly significant difference, OAGB resulted in the achievement of the successful changes in a bigger proportion of patients compared with the other surgical technics. Furthermore, many other variables that showed differences between groups such as lack of a full time job, previous abdominal surgery or depression/anxiety are described and the results of the multivariate analysis depicted in Table 3.

In order to make an effort to satisfy the exposed comments, we have reviewed the literature again and we were unable to locate any other data that could explain the above mentioned differences. We added this comment on the discussion, which may be will encourage other investigators to further continue these analysis.

The limits should be specified better.

We acknowledge that the main limitations of this study are: its retrospective nature, with the memory biases that this implies and the lack of a standardized method for the evaluation of nutritional and exercise patterns that patients had after surgery. These comments are written throughout the discussion (lines 297 and 310, 338-334) and in the conclusions (line 351-353).
We have re-written some of the lines to make it more understandable. However, it is the first study, to our knowledge, that includes patients with 3 types of bariatric surgeries, which focuses on the group of patients who are not responding satisfactorily to the surgery (12 months after surgery) and who It reflects the limitations in care that are lived every day in a care center like ours.

We are on track for publication but the paper needs further revision. We appreciate your time and comments.