Response to reviewers' comments

1. Comment 1: Uneven grouping (43 vs. 73 patients)

Response:

We acknowledge your comment. The uneven distribution between the two groups reflects real-world practice patterns and drug availability during the study period, which was a retrospective analysis. This clarification was added and highlighted in the methods section. Despite the difference in sample sizes, statistical methods appropriate for unequal group sizes (e.g., Mann-Whitney U test, Fisher's exact test) were employed to minimize potential bias.

2. Comment 2: Request for raw data in supplemental files

Response:

We agree with the reviewer's suggestion. The anonymous raw data (pre- and post-treatment parameters) for each patient will be provided in a supplementary Excel file upon manuscript resubmission to enhance transparency and facilitate future meta-analyses.

3. Comment 3: Unclear statistical methods used in Tables 1–3

Response:

Thank you for the observation. We have revised the Methods section to clarify the statistical tests used:

- Table 1: Student's T test for mean (Parametric) and Pearson Chi-square or Fisher's exact test for categorical variables.
- Table 2: Student's T test for mean (Parametric) and Mann-Whitney U test for median (non-parametric) and Pearson Chi-square or Fisher's exact test for categorical variables.

- Table 3: Pearson Chi-square or Fisher's exact test for comparing proportions of adverse events.

These details were added to the table legends and Methods section.

4. Comment 4: Inclusion of 7-year-old patients despite eligibility criteria of ≥12 years or >35 kg

Response:

Thank you for pointing this out. All patients included met the inclusion criterion of either being ≥12 years old or weighing >35 kg (even if less than 12 years). The 8-year-old case in the Harvoni group who weighed> 35 kg had glycogen storage disease and the 7-year-old case in the Ledisbuvir group who weighed> 35 kg had Down syndrome thus were qualified for treatment. These details were added in the results section for clarification.

5. Comment 5: Inconsistencies in comorbidity data in Table 1

Response:

We appreciate this observation. The percentages for comorbidities were initially calculated based on the total number of patients with comorbidities, which may lead to confusion. We have recalculated and revised Table 1 to reflect percentages based on the total number within each treatment group, and the text has been modified accordingly.

6. Comment 6: Baseline bilirubin and INR differences – clinical relevance?

Response:

Although total bilirubin and INR were statistically higher in the Ledisbuvir group, both parameters remained within normal reference ranges and did not signify hepatic dysfunction. Subgroup analyses revealed no impact on SVR or adverse events. We have clarified this in the Results section.

7. Comment 7: Inconsistent expression of continuous variables (mean ± SD vs. median [IQR])

Response:

We appreciate your observation. Non-parametric variables were presented as median (IQR), and normally distributed data as mean ± SD. Justification for the choice of format was included in the revised Methods section.

8. Comment 8: Discrepancy in Fibroscan sample size (Table 2: n=72 for Harvoni group)

Response:

One patient with mesangioproliferative glomerunephritis in the Harvoni group could not perform Fibroscan due to marked ascites. This explanation was added as a not under the related table (Table 2).

9. Comment 9: Misleading calculation of adverse event percentages in Table 3

Response:

We appreciate this important note. Percentages were initially calculated based on the number of patients who experienced adverse events rather than the total group size. We have recalculated the data to reflect incidence per treatment group, and revised Table 3 accordingly.

10. Comment 10: Lack of cost data despite emphasizing economic advantages

Response:

Thank you for your insightful comment. We have now added comparative cost data in the Discussion section. Specifically, we mentioned that the use of the generic formulation of DAAs which is available at approximately 2200 EGP, represents a highly cost-effective alternative to the original Harvoni, priced at around 9000 EGP, offering comparable efficacy at a substantially reduced

financial burden (Waked et al., 2022). This supports the conclusion about cost-effectiveness.

11. Comment 11: Long table titles

Response:

We have shortened the table titles by removing redundant phrases while retaining clarity.

12. Comment 12: Ethics approval number not mentioned

Response:

Thank you for highlighting this. The ethics approval number from Cairo University's IRB will be added to the "Patients and Methods" section as: "The study protocol was approved by Cairo University Institutional Review Board (approval number: N-173-2024