RESPONSE TO REVIEWERS

MINOR POINTS:

[1] GENETICS: ? In Figure 1 it should be clearer (eg. Larger text, bold text) that the genes in the boxes (esp. NOD2) are NOT involved in Indian IBD.
Changes done in the figure.

[2] MECHANISM: ? A comparisojn of epidemiological features of IBD in India compared to other local regions would be of interest – eg. Hong Kong (Ng, S et al) and New Zealand (Gearry, R et al).
The epidemiological features of IBD in India (in the few studies that is available) has been summarised in Table 1 and these have been compared to the ACCESS study group data which states the epidemiological features of IBD in other parts of Asia.

[3] ? Can the authors postulate any reasons (eg. Diet, hygiene, genetics) for the different epidemiological features of disease between North and South India?
The postulated reasons have been mentioned in text.

[4] ? The role of mycobacterium paraTB and the importance of intestinal permability are both debateable and not specific to IBD in India– these sections could be briefer, if not left out
The section is left out with addition of a single line stating their debatable nature.

UC:

[5] ? Table 1 is too large and difficult to read. A single table summarizing the features of UC that are more unique to India would be more useful, with references as footnotes.
The tables of clinical features of UC and CD has been replaced by a more meaningful one comparing the clinical features in India with other regions of Asia. For this the data on UC and CD collected from all over India by the Task Force on IBD (hence representative of the whole country) is compared with those of other parts of Asia and Australia collected by the ACCESS study group. It is also appropriate as Indian representation was absent in the ACCESS data.

[6] ? Are 80% of disease flares really due to non-adherence?
This part is deleted

[7] ? Some EIMs do parallel disease activity (eg. Large joint arthropathy, erythema nodosum) – if this is not the case in India then this is unique and should be highlighted more.
This is not unique to India so deleted.

[8] ? The data of CRC risk in Indian UC populations do not noffer the reader any guidance as to recommendations for surveillance. Even with an imperfect evidence base, as is acknowledged, some recommendation should be given.
Whatever early data on UC related CRC is available has been summarised in a table and an early recommendation has been done.

CD:

[9] ? Table 2 is again too big and a similar recommendation to the UC table is recommended.
As in [5] above.

[10] ? Is there any reason why occult small bowel bleeding is a commoner presentation in Indian CD?
Possible reason mentioned in text.

[11] ? 5-ASAs are generally ineffective in CD. If it is to be claimed they are effective in Indian populations then some references are required.
References mentioned.

[12] ? ASCA is one of the MAIN ways we differentiate CD and TB in Western countries – is this really different in India?
The references are given

SUMMARY:

[13] ? How can an increase in prevalence in India be predominatly due to genetics, rather than environmental changes – this is counter-intuitive to most research indicating the increased prevalence in developing countries is due to "Westernisation"?
The language has been modified to convey the sense which was meant.

MAJOR POINTS:

[14] ? The author has produced an interesting review manuscript however it is overly long and does not have a clear message and practical management recommendations for clinicians.
The manuscript have been much shortened without deleting important points. Though the database is not strong enough to give clear recommendations, important points on genetics, race, epidemiology and clinical features have been discussed which may help practical management. The section on clinical features have been reframed by discussion on IBD in India as a whole (rather than discussing UC and CD under separate headings) and comparing it to other regions in Asia to make it shorter and more meaningful.

[15] ? Further epidemiological comparison between the differences in IBD in India versus other developing countries (eg, in other Asian countries) would be of interested, rather than just comparisons with IBD in the West.
This has been done as stated above.

[16] ? The tables and figures are too large and impractical
The tables have been done away with and replaced by much more meaningful ones.

[17] ? Minor grammatical errors throughout the manuscript could be easily corrected with English language spell and grammar check.
Done.