Review 2

The manuscript of Ludlow et al. deals with the assessment of malnutrition rates in patients of advanced liver disease (ALD), since malnutrition is detrimental for quality of life and social, emotional and psychological wellbeing. Authors integrate non-physiological factors having influence on malnutrition risk. This qualitative study aimed to understand the holistic factors influencing nutritional status in the ALD population. Semi-structured interviews covered five key themes: (i) appropriateness of healthcare delivery; (ii) health and food related factors; (iii) high symptom burden, (iv) social support impacting wellbeing and (v) physical and structural supports. Authors concluded that inclusion of both physiological and non-physiological factors in ALD malnutrition screening may promote more timely and comprehensive nutritional interventions. This work appeared to be well performed, showing interesting data. However, I have some minor concerns:

Many thanks for your positive comments regarding the aim of our study. Please see our responses and details of the amendments made to the manuscript below:

1) Assessment of malnutrition rate was performed in ALD with patients classified as Child-Pugh B or C liver disease; There were also tested nutrition rates in patients with Child-Pugh A? Indeed, malnutrition contributes to the advance of this disease?

This qualitative research includes semi-structured interviews exploring consumer views on the factors that could lead to malnutrition to provide lived experience. These consumers (n=9) had Child Pugh B or C liver disease and attended complex and supportive care liver clinics in a metropolitan and regional public health service. To clarify our consumer input, we have added 'As a range of lived experience was sought, current malnutrition was not an inclusion criterion for the study; participants were invited if they had Child-Pugh B or C status as this group would be more likely to have a current or future risk of undernutrition and receive dietetic input.' [lines 107-110].

We agree that timely nutritional intervention in people with Child-Pugh A status remains important, and therefore their views as consumers may be useful in a broader study. We have noted this as a potential limitation: 'This study did not include patient participants with Child-Pugh A status, and although it is anticipated that this would not have changed our themes, this could be another area of future study' [lines 332-334].

2) Besides the data analysis, why a statistical analysis was not applied? How was calculated the "n" of patients necessary to reinforce the conclusions?

This was a qualitative study with transcripts of the semi-structured interviews and exploration using the Braun and Clarke method for thematic analysis. Sample size in qualitative studies is not ascertained using a power calculation as is common in quantitative research; rather, sample sizes are guided by information power. We have amended the data analysis section of the paper to clarify accordingly: 'The sample size was deemed large enough to provide adequate information power due to the narrow focus of the study, specific sample population, and clinical expertise of the research team', referenced as Malterud K, Siersma VD, Guassora AD. Sample Size in Qualitative Interview Studies: Guided by Information Power. Qual Health Res. 2016 Nov;26(13):1753-1760. [lines 162-164]

The conclusion of this qualitative study has enabled the design of an interventional study in a new cohort, comparing a novel holistic screening tool with a subjective global assessment for all participants, as we herald in the final paragraph of the discussion. As would be expected, this follow-on study includes a full quantitative statistical analysis. We have made this more explicit: 'The authors plan to develop a novel screening tool for ALD, that will be evaluated in comparison to a comprehensive subjective global assessment'. [lines 343-344].

3) The concept of malnutrition relies in the amount of ingested food, its quality or the frequency of meals?

Malnutrition in ALD can occur because of both reduced meal frequency and quality; however, reduced meal quality due to anorexia, early satiety, ascites and gastrointestinal symptoms is more common. In this study, clinicians, patients, and carers were asked open questions about factors influencing nutrition, rather than specific questions regarding meal frequency or quality (Table 1 and 2). However, we did note that symptoms may impact the ability to shop and prepare meals, which could reflect meal frequency; however, measurement of meal frequency, for example using a validated food frequency questionnaire, was not the aim of the study. We also noted that finances may influence the amount of food that was affordable, which could influence food quality, although measurement of meal quality was also beyond the scope of the study. This is an interesting suggestion and we have added it to the discussion: '….and the factors that may differentially influence meal frequency or meal quality (may also benefit from future research)'. [line 335].

4) It seems that the main non-physiological factors relay in a depressing behavior and in the economical status. How these factors can be analyzed in depth?

The non-physiological factors that were identified in this study included financial status, level of food literacy, and level of sociological support. The aim of this study was not to establish a hierarchy of physiological or non-physiological factors. However, including these factors in a novel screening tool may allow a sensitivity analysis to determine the strength of the relationship between each factor and a subjective global assessment as the diagnostic evaluation of nutritional status. We have included in the last paragraph of the discussion: 'The authors plan to develop a novel screening tool for ALD, that will be evaluated in comparison to a comprehensive subjective global assessment'. [lines 342-343].