

Dear Editor

We have rewritten the manuscript according to the comments of the reviewers, including the suggested changes. We have also carried out a more important revision of all the sections.

Thank you very much for your comments

Responses to reviewer 1

First, I would like to thank you for your effort in reviewing the manuscript. Second, I have included all the changes suggested by the reviewers

1. What will be the future impact of this study? How this study could help the scientific community? Please highlight these details.

The present study shows that having a telemedicine system strongly implanted in a health territory can reduce the effect of a new pandemic that makes it difficult for patients to be physically present during patient medical visits. In any case, we have to improve telemedicine systems since a not insignificant part of the patients studied worsened during the pandemic, surely those who were already poorly controlled.

2. The study is just providing the data of screened patients during the COVID-19 period but what if the number of patients was increasing? The study doesn't answer or focus on key questioning or doesn't conclude any future aspect of the study.

Certainly, the study was based only on diabetic patients who were already diagnosed and who were known by the health system. We do not know what has happened in patients who were not diagnosed with diabetes during the covid period. I have included a sentence about it in the limitations of the study.

Responses to reviewer 2

First, I would like to thank you for your effort in reviewing the manuscript. Second, I have included all the changes suggested by the reviewers

Commentary. The author tried to use follow-up data to explore the influences of COVID-19 on diabetic retinopathy, which is potentially meaningful in managing DM patients. Here are my comments:

1. It is generally known that diabetic retinopathy is highly associated with the duration of diabetes history and general control of glycemia when each follow-up. As the author only mentioned glycemia, the relationship among diabetes / DM / COVID-19 influence were somehow less convincing. Adding relative information and taking diabetic history into account is highly recommended.

Thank you very much for this comment, I consider it important and it was a mistake on our part not to include it. In the new version I have included the data obtained in the statistical study of the sample, according to age, sex and time of evolution of DM. The statistical results over the years studied do not give a significant statistical result.

2. As the mean age of the database was over 60y/o, qualities of fundus images may affect by cataracts, which small microaneurysms may be missed. So in the general ophthalmology clinic, the screening of DM is mainly based on fundus fluorescence for patients with 50y/o who suffered from diabetes for years, if possible. Fundus fluorescence is a key step in managing diabetic patients, the author should mention this information in the limitation section if lack of these data.

It is true, the opacity of the media makes it difficult to see the fundus, especially if only retinography is performed using a non-mydratic camera, although the images with the new equipment have improved a lot, there are always around 3% of patients who do not visualize the queen well, in these cases what we have done is visit them in the ophthalmology service in person, even during the pandemic and resort to other diagnostic systems such as OCT, or angio-OCT. We have included this comment in the methods section.

3. The information shown in Figure 2 seems to have covered Figure 1. Please refrain to show redundant figures.

Thank you very much for this comment. We have eliminated figure 2 and have made figure 2 the only figure in the manuscript.

4. According to the results shown in Table 1, the patients' number of 2021 showed a bounce compared to 2020. One may think that data in 2020 may be "those patients who have to follow-up despite of COVID-19 pandemic", these patients may be potential severer DM. Furthermore, the 2021 data may somehow be like a data-delay condition, instead of those patients whose DM conditions got severed. Because the author did not mention how many patients in 2021 overlapped those follow-upped in 2020 (patients visited the hospital both in 2020 and 2021), how did the author consider this point?

Thank you very much for this comment. We have carried out the study suggested by the reviewer, on the number of patients not visited in 2020 and that, if they were visited in 2021, we have included the data obtained in the results section.

Certainly, there is a significant proportion of patients who should have attended in 2020 (we know who they were because they failed to be cited in 2020 and who did attend in 2021. We have analyzed the data of these patients and they did not show a significant difference in factors of risk (age, DM duration, arterial hypertension control and HBA1c) with respect to the group that should already be visited in 2021. Because there is an excess of data, he sent the data to you, but in the manuscript, we only refer to this point without providing the data in the discussion.

In total, 1,097 patients in 2020 were seen in 2021, that is, 17.97% of those seen in 2021 should have been seen in 2020. If we observe the differences according to age, sex, DM duration, HbA1c, and differences in blood pressure, the data indicate that there are no significant differences according to the table;

	2020 *	2021**	p
	1097	5007	
Age	67.61 ± 8.12	67.57 ± 8.04	0.502
Sex (women %)	46.52	46.32	0.374
DM duration in years	9.10±6.81	9.14±6.93	0.324
HbA1c (%)	7.52±1.71	7.51±1.69	0.103
eGFR (ml/min/1.73m2)	79.91±23.81	79.97±24.84	0.230
TAS (mmHg)	134.52±23.42	132.67±23.37	0.330
TAD (mmHg)	77.61±11.31	77.52±11.28	0.304

2020* patients visited in 2021 but cited in 2020 and who did not attend.

2021*+ patients cited in 2021, whose visit was already scheduled

5. The discussion part should be reorganized, instead of repeating the results section. The authors should deeply insight into the data and discuss the potential social factors of showed data, for example, increased DM prevalence affected by lack of medicine due to COVID-19? Or longer stay-at-home time? Or any other reasons. Analyzing these aspects may indicate us to manage DM patients in the future.

We have rewritten the discussion to be more narrative and study-based rather than schematic.

6. In addition to comment #5, the conclusion section seems also did not summarize the core content or have feasible indications of the clinical work, it should be reorganized.

We have rewritten the conclusions to be more in accordance with the results of the study.