Peer Review File

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Reviewer A

Comment 1: the whole article requires complex language editing before publication

Reply: We acknowledge this remark, proofreading has been done, and basic grammatical errors corrected

Comment 2: in some places, please correct the HF nomenclature pitfall - change the 'mid-range' term to 'mildly-reduced' in accordance with recent ESC guidelines

Reply: We appreciate this keen remark, heart failure with mid-range ejection fraction updated to heart failure with mildly reduced ejection fraction

Change in text: Page 14

Comment 3: regarding echocardiographic parameters: please provide the exact adopted definition of pulmonary hypertension; as has been pointed in Table 1 valve disease has been stated in around half of patients - please highlight the number of patients with only severe valve disease

Reply : Thank you for this pertinent comment. Pulmonary hypertension (PH) was diagnosed by the attending cardiologist using echocardiography as a right ventricular systolic pressure >35 mm Hg, in absence of pulmonary stenosis and acute right heart failure. We have added this definition in the method section (page 4, line 15-17).

Any valvular dysfunction on cardiac echo was described for the entire cohort, however, 9.5% of HF were due to valvular diease

Change in text

Comment 4: regarding pharmacotherapy: diuretics were the most commonly used class of drugs in this population - were they just loop diuretics? furosemide? torasemide? or also thiazide-like diuretics?

Reply: Thank you for this remark, information on specific types of diuretics included in the text

Change in Text: Page 6, line 1-3

Comment 5: in the Discussion section please add also a short paragraph comparing your results regarding pharmacotherapy with large current American/European registries

Reply: We agree with this suggestion, A paragraph has been included in the text providing information on pharmacotherapy

“Diuretics are recommended by several cardiology clinical society guidelines in HF patients especially in patients with HFrEF to alleviate congestive symptoms [18,19]. Majority of the participants in this cohort where on diuretics (loop or thiazide). Four standard drug therapies such as angiotensin-converting enzyme (ACE) inhibitors or angiotensin receptor/neprilysin inhibitors (ARNIs; sacubitril/valsartan), beta-

blockers, mineralocorticoid receptor antagonists (MRAs) and SGLT2 inhibitors are now well established to provide incremental benefit in patients with HF, with marked reduction in mortality and all-cause hospitalizations [20]. Due to unavailability and costs concerns, our patients could only access ACE inhibitors, beta blockers and MRAs, and less than 50% of those with HFrEF could access the all 3. In addition, none received interventional or device therapies for personalized treatment of HF confirming that there is still be a door for improvement of prognosis of our patients using modern therapies as per clinical guideline recommendations

Change in text: Page line 11-22

Reviewer B

Comment 1: The introduction and results sections need more flow

Reply: This has been effected

Comment 2: Please include the references discussing how variables were selected for the univariate analysis

Reply: Thank you for this keen remarks, references added in in text

Change in text: page 5 line 7

Comment 3: Please elaborate on the follow-up method, timing, and frequency used

Reply: We humbly acknowledge this remark, information on follow-up updated in text.

"We assessed patients at six months intervals from index date of inclusion into the registry, participants were informed on regular basis via telephone two weeks prior to follow up dates, and were invited to their respective study centres for clinic-based follow-up. In situations where a participant was unable to make it to their study centre, telephone-based follow-up was conducted. Participants were considered lost to follow-up after consecutive weeks of unsuccessful telephone contact with participants or their family members. End of study follow-up was conducted at 36 months (±4 weeks) after their inclusion in the registry.. All-cause mortality within the follow-up period was our outcome of interest."

Change in text: Page 4, line 18 – 26

Comment 4: Manuscript has several syntax errors and would benefit from proofreading

Reply: Thank you for this remark to help us improve the quality of this manuscript, proofreading has been done by authors and basic grammar and syntax errors corrected.

Reviewer C

The study has specific goals, was carried out on a sufficiently large number of patients, it contains some interesting hypotheses.

Patients diagnosed with HF (heart failure) in the study group were not divided into NYHA classes I, II, III, IV. It is necessary to divide and recalculate the parameters for these classes, or at least to separate two groups I / II and III / IV according to NYHA.

Likewise in the conclusions it is mentioned that patients died (lines 203-206) but not divided into NYHA classes. Ideally, the results should be related to each patient's EF (Ejection Fraction) parameters.

In connection with the above, similar reservations can be made to the conclusions and final results.

The study requires a thorough change and recalculation of the results according to the described scheme and reservations

Reply: We thank the reviewer for his pertinent comment. We have effected this, doing both recalculations and Kaplan Meier survival analysis.

The baseline characteristics have been recalculated based on the NYHA categories. Also, the description of the first part of the result section has been reworded based on these recalculations

Change in Text: Table 1, Figure 5, Page 5 lines 11-27