OPEN PEER REVIEW

Open Peer Review (OPR)

As a new feature for progressing towards transparency, we decided to open a new window for all of our editors as well as authors titled "**Open Peer Review**". We hope by this new facility, our reviewers will be more motivated and authors will be more satisfied with the review process. We believe that publishing our peer review reports could make a transparent and clear environment for all our efforts within a journal, but not all reviewers tend to publish their comments.

What is "Open Peer Review" process?

An "Open Peer Review" process is making the details of all review process (including reviewers, associate editors, and EICs comments) as "Public" as it is agreed by EIC, Authors, and reviewers.

Advantages of "Open Peer Review" process

- More transparency, constructiveness and tactful comments of the peer review process: leads to an increase in the quality of reviews
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- Education of both authors and new students
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You can find out more at:
https://sites.kowsarpub.com/kowsar/knowledgebase/category/tree.html#opr.html

Asian Journal of Sports Medicine
Article DOI: 10.5812/asjsm.101808
Published in: Asian Journal of Sports Medicine: 11(2); e101808

Peer Review Report for "Reference Values and Predictive Equations for Cardiopulmonary Exercise Testing in Thai Adults"

Author(s): Prapaporn Pornsuriyasak, Kitipong Ngaojaruwong, Suchada Saovieng, Jayanton Patumanond, Khanat Kruthkul, Rungchai Chaunchaiyakul

Review Timeline:

Submit Date: 15 Feb 2020
Revised Date: 4 Apr 2020
Accepted Date: 24 Apr 2020

Revision (0)

Here, you can see the **Reviewers**, **Associate Editors** and **EICs'** comments from the beginning to the end of the revision process.

REFEREE: Reviewer | **Revision** (0)

9 Mar 2020

Dear AE,
comments for the authors:
- The most important aspect of this manuscript is that there is currently no reasonable prediction equation set for the Asian population either for estimating the normal population, athletic population, or clinical patient clientele. This is especially problematic when one needs to evaluate the exercise tolerance of patients and to compare the values to those of the normal healthy, age and sex-matched population. This work elegantly fills this gap and will be an important reference for the Asian population.
- There are no major comments or objections from this reviewer. However, there are several minor points that authors might want to address before publishing.
Abstract:
- How was sex included in the equation? Was it apriori selection which equation is to be used (for males and females)
- Last sentence in the abstract: correct heath to health.
- Second sentence of Background: Additionally, the physiological responses are different on a treadmill in several aspects, the maximal oxygen uptake is usually higher by about 10 to 15%. For reference, please see Porszasz et al. Ch 3. ERS Monograph Series, Vol 80,

1918). Therefore, the predictive equations should also discriminate by the exercise modality.

- Page 3: Point 3.1 Subjects – last sentence:

- This condition is a bit vague! I don't think, it is enough to judge whether the exercise responses of these individuals were necessarily 'normal'. Especially that if we consider what is 'normal' in a study specifically addressing the "normality" as its goal.

- I would suggest to think, whether a different statement would be applicable: "Patients with abnormal blood pressure responses or signs of myocardial ischemia or those, who stopped exercising due to any other reasons than intolerable fatigue should be excluded. In other words, a statement saying that 'the exercise tests were conducted to the limit of subjective tolerance and no test was stopped because of any medically abnormal signs or symptoms" would be warranted here.

- Page 3, last paragraph: This section is all right, however I would still think that the above suggestion still stands and recommend adding something like that.

- Page 4: first sentence: add reference to GPAQ

- Second sentence: if you obtained spirometry, a statement in the previous section saying that "anybody with abnormal spirometry was excluded" would be adequate

- Delete rate after ‘Cadence’ - there is no need for ‘Cadence rate’

- Modified Borg scales: This was probably the Category Ratio Scale (CRS) by Borg - Please give reference to this

- Plateau for how long (30 seconds or 1 minute? It is difficult to see a plateau-like that if you have only one point per 30 seconds. It would have been better if you do a 10 sec average, than it would be 6 points per minute and a plateau would be defined clearer - I don't want you to recalculate everything, but this section probably should be taken out

- You cannot declare a 20-sec average as taken for VO2max when your averaging interval was 30 sec!

- VT1 is less acceptable: please use lactate threshold or lactic acidosis threshold instead

- You MUST define how the plateau was assessed if that is the FIRST criterion for maximal exercise - it is problematic when you have a contradiction between the available points (one every 30 seconds) and that the VO2max was taken as the "highest value in 20 second averages" - how did you get 20 sec average from a point that is representing 30 sec average?

Page 5:

- Beaver et al. did not define this as VT1 (!)

- Granted, it is important to be able to determine the threshold. However, the criterion of not being able to find it on the V-slope method and moving on to the ventilatory equivalents and if the threshold was not possible to be determined, the set of data should not have been discarded. There are other signs, i.e. the PETO2 and PETCO2 as well as the time course of RER that could help. It is important to realize that ALL of these have to agree pointing to the LAT. These are just different signs of the same physiological changes as a response to metabolic acidosis.

- The reference (19) should be given at the first occurrence of GPAQ

Page 6:

- Again, you MUST define how the plateau was assessed. I am sure it was based on the Breath By Breath data on the Vmax display, but somehow you MUST get to the definition. Based on the 30-sec average you simply just cannot do it.

- These are well-established signs of maximal exercise - however, none should be used to INDICATE that the exercise SHOULD be stopped.
- On the other hand, if the exercise IS stopped by indications of INTOLERANCE, these signs usually show these values.
- Put the P-value in parentheses if you write them into the text.
- Did you analyze the VO2 at the LAT and at peak (VO2peak) as a function of activity? Was the VO2 at the LAT and at peak correlated with physical activity?
- If so, it would be nice to show

Page 7:

- It would be nice to see the ratio of VE to the MVV (you had spirometry in all of them, therefore the indirect MVV could be calculated as FEV1*40. Can you compare these between age groups and sex groups? It would give a nice insight into the changes in 'ventilatory demand' if one exists. Alternatively, it would be nice to see if the ventilatory demand is not changing and individuals stop exercising at the same level of ventilatory demand.
- Ventilatory equivalents section: Predictive equation paragraph needs to go under a different header (not Ventilatory equivalents.)

Page 8:

- Comment to value [1.795 (0.39 L.min-1]: I think this value for the Indian population might already be significantly lower than that of the Thai males.
- Further down, 1.292 is for Indian females?

Page 9:

- “Note that V’Epeak…”: This cannot be stated unless the underlining power (work rate) is also considered. Therefore, the work rate should also be included in this discussion (or somewhere else).
- Be careful, because stating the VEPeak is smaller in the Thai population, one might think that it is lower, becasue the Thai people need to breathe less - which is obviously not right.
- The VO2peak, HRPeak, and VEPeak cannot be compared without comparing the Peak Work Rate also.
- DETERIORATED? What do you mean? VE/VO2 and VE/VCO@LAT should be <~30 in both sexes. During rest and above the threshold VE/VO2 is higher - in fact, it is increasing without an increase in VE/VCO2 (as it is said when you determine the threshold). And so, deterioration needs a thorough explanation, what do you mean???
- Don't mix the VE/VO2 and VE/VCO2 (the ventilatory equivalents) with the VE/VCO2 slope. The latter one is the slope of the straight line on the plot of VE vs. VCO2 up to the respiratory compensation point (RCP).

Page 10:

- ‘…our subjects had hypertension and diabetes mellitus … ‘ -- Not ALL of them, you must be careful to say this... if it is true, the population you have used is NOT healthy, but hypertensive and diabetic... ALL of them were like this? No, only a ???% of the whole population had either hypertension or diabetes.

Page 11, Table 1.:

- The statistical test providing the P-value for a frequency analysis should be stated.

Page 12, Table 2:

- This table MUST have Peak Work Rate values. Without work rate, the maximal values cannot be compared! If you do, the conclusion is going to be misleading!!!

- Last two lines of Table 2 males and also females: Are these Ventilatory Equivalents measured at PEAK exercise or at the THRESHOLD? This should be stated - I think both should be listed here (the VE/VO2 nadir and VE/VCO2 nadir - lowest point (which, for the VE/VO2 probably is at the threshold).
Table 3:
- Again - the Ventilatroy Equivalents are smallest at the threshold (these values should be stated and the regression equation should also be dealing with the smallest point! That makes more sense.
Page 19:
- Consider reporting the Standard Error of Estimate values for all regressions. That is the parameter that is most useful in seeing the accuracy of the prediction.
Page 20:
- Scatter plots! (not scattered...) - Something is strange with this: it should be V'O2peak
Page 23:
- Scatter plot
- V'Epeak
- V'E/V'CO2
Page 24:
- Scatter plot
- V'O2peak
- V'O2 at VT1 (or better yet, at LAT (!)
Thanks.

REFEREE: Associate Editor | **Revision** (0) 9 Mar 2020

Dear EIC,
I am pleased to inform that we have gathered valuable reviews, please address all the comments.
Thanks.

REFEREE: EIC | **Revision** (0) 12 Mar 2020

Dear Author,
Thank you for submitting your manuscript to Asian J Sports Med. I now have the reports of the Referees, which suggest that your manuscript might be suitable for publication following a number of revisions. I attach some reviewer comments and invite you to submit a revised version of your manuscript addressing the points made.
Thanks.

OPEN PEER REVIEW

Revision (1)

Reply to Reviewers

Ideally, the reviewing process can significantly improve the submitted manuscripts by allowing the authors to take into account the advice of reviewers. Author(s) must reply to all reviewers' comments in a separate Word file, point by point. A "**Reply to Reviewers**" document is submitted along with revised manuscript during submission of revised files, summarizing the changes that the authors made in response to the reviewers' comments. The responses to reviewers' comments specifies how the authors addressed each comment the reviewers made.

You can read the authors' responses to the reviewers' comments in the next page.

Responses to the reviewer's comments

We appreciate the comments of the reviewer and try to address, with point-by-point responses. The revisions are made according to the reviewer's comments and highlighted in the manuscript. We hope that our manuscript has been approved for publication in Asian Journal of Sports Medicine very soon.

Reviewer's Comments:

Reviewer 1:
Reviewers comments to ID: 101808, Reference Values and Predictive Equations, submitted to Asian Journal of Sports Medicine.

The most important aspect of this manuscript is that there is currently no reasonable prediction equation set for Asian population either for estimating the normal population, athletic population or clinical patient clientele. This is especially problematic when one need to evaluate the exercise tolerance of patients and to compare the values to those of the normal healthy, age and sex matched population. This work elegantly fills this gap and will be an important reference for the Asian population.
There is no major comments or objections from this reviewer. However, there are several minor points that authors might want to address before publishing.

Thank you for your valuable comments.

Abstract:
- How was sex included in the equation? Was it a priori selection which equation is to be used (for males and females)

Our reply: *Previous literatures strongly indicated the different amounts of muscle and fat mass between gender. Thus we took gender as a priori for the equations. The clear distinction on the effects of gender are already defined separately for both gender in Table 3.*

- Last sentence in the abstract: correct heath to health.

Our reply: *We did correct the error in the abstract.*

Second sentence of Background: Additionally, the physiological responses are different on treadmill in several aspects, the maximal oxygen uptake is usually higher by about 10 to 15%. For reference, please see Porszasz et al. Ch 3. ERS Monograph Series, Vol 80, 1918). Therefore, the predictive equations should also discriminate by the exercise modality.

Our reply: *Since the traditional modality for physical fitness test are treadmill and cycle ergometer, we realized that the test results are quite different and should discriminate by the exercise modality. We then replace the previous citation with the work of*

Porszasz et al. as suggested. We inserted a few sentences (Line 9-11 in the new manuscript) as suggested in the manuscript.

Additionally, the physiological responses are different on treadmill in several aspects, the maximal $\dot{V}O_2$ is usually higer by about 10 to 15% (3). Therefore, the predictive equations should discriminate by the exercise modality.

Page 3: Point 3.1 Subjects – last sentence:
This condition is a bit vague! I don't think, it is enough to judge whether the exercise responses of these individuals were necessarily 'normal'. Especially that if we consider what is 'normal' in a study specifically addressing the "normality" as its goal.

I would suggest to think, weather a different statement would be applicable: "Patients with abnormal blood pressure responses, or signs of myocardial ischemia or those, who stopped exercising due to any other reasons than intolerable fatigue should be excluded. In other words a statement saying that 'the exercise tests were conducted to the limit of subjective tolerance and no test was stopped because of any medically abnormal signs or symptoms" would be warranted here.

***Our reply**: Thank you for your comments. We did correct as follows.*

Subheading 3.1 Subjects: We omitted the last paragraph that is the following.

Thirty-eight subjects were excluded before CPET was performed because they did not meet the inclusion criteria (Figure 1). Of the 542 subjects enrolled for CPET, 59 subjects were subsequently excluded from the analysis because their CPET results showed poor quality, characterized by a respiratory exchange ratio (RER) of less than 1.1, or a maximal heart rate (HR_{max}) during exercise of< 85% of the age-predicted maximum values (220−age) (1).

Subheading 3.2 Procedures: We inserted a sentence as suggested (Line 58-60 in the new manuscript).

Subjects with abnormal blood pressure responses, or signs of myocardial ischemia or those who stopped exercising due to any other reasons than intolerable fatigue were excluded.

Page 3, last paragraph: This section is all right, however I would still think that the above suggestion still stands and recommend adding something like that.

***Our reply**: We decided to keep the last paragraph (Line 68-70) except for reaching VO2 plateau. We think that intolerable fatigue reported by the subjects is the most important criteria for maximal exercise. However, the other criteria i.e., criteria 2 (HR) and criteria 3 (RER) were used as complement criteria during a retrospective review by one of the*

authors (PP.) to select; at least, the satisfactory CPET results that were performed by technicians for analysis.

Page 4

First sentence: add reference to GPAQ

***Our reply**: We inserted reference # 16 as mentioned for GPAQ citation.*

Second sentence: if you obtained spirometry, a statement in the previous section saying that "anybody with abnormal spirometry was excluded" would be adequate

***Our reply**: We remove the word “spirometry” from line 47 according to a statement in the previous section saying that "anybody with abnormal spirometry was excluded.*

- Delete rate after ‘Cadence’ - there is no need for ‘Cadence rate’

***Our reply**: We delete the word “rate” after cadence (Line 56).*

- Modified Borg scales: This was probably the Category Ratio Scale (CRS) by Borg - please give reference to this.

***Our reply**: We changed Modified Borg scales to “modified Borg’s numerical rating scales” and the reference was cited in the reference # 17. (Line 58)*

- Plateau for how long (30 seconds or 1 minute? It is difficult to see a plateau like that if you have only one point per 30 seconds. It would have been better if you do a 10 sec average, than it would be 6 points per minute and a plateau would be defined clearer - I don't want you to recalculate everything, but this section probably should be taken out

***Our reply**: Thank you for your comments.*

We decided to take out the determination of the VO2max from the VO2 plateau that was from 20s-average data.

-You cannot declare a 20 sec average as taken for VO2max when your averaging interval was 30 sec!

***Our reply**: Thank you for your comment.*

With options from Vmax Software, we could set a breath-by-breath, or 10, 20, 30 and 60 s-average. We decided to determine VO2peak from 30 s-interval at the nearest exhaustion. (Line 60-61 in the new manuscript)

We decided to take out the determination of the VO2max from the VO2 plateau that was from 20s-average data and focused only on the VO2peak and keep the following sentence.

The CPET data were interval averaged every 30 seconds, and the highest $\dot{V}O_2$ nearest 30s- before exhaustion was chosen and considered as $\dot{V}O_{2peak}$.

- VT1 is less acceptable: please use lactate threshold or lactic acidosis threshold instead

***Our reply**: Thank you for your valuable comment.*

We replaced VT 1 with lactic acidosis threshold (LAT) everywhere in the new manuscript.

- You MUST define how the plateau was assessed if that is the FIRST criterion for maximal exercise - it is problematic when you have a contradiction between the available points (one every 30 seconds) and that the VO2max was taken as the "highest value in 20 second averages" - how did you get 20 sec average from a point that is representing 30 sec average?

***Our reply**: VO2 plateau was based on the retrieved Breath-By-Breath data on the Vmax display that utilize the fixed-width box of 20 s to identify the VO2 at peak exercise. We agree that it is not a correct method as you mentioned, therefore we decided to take out this section.*

We also rewrote as follows: Line 67-70

"To determine the VO_{2peak}, all CPET data were reviewed by an investigator (PP) and considered for analysis when all of the following criteria were met…."

Page 5:
- Beaver et al. did not define this as VT1 (!)

***Our reply**: Thank you for your valuable comment.*

Agree! We replaced VT1 with lactic acidosis threshold (LAT) in the manuscript.

- Granted, it is important to be able to determine the threshold. However, the criterion of not being able to find it on the V-slope method and moving on to the ventilatory equivalents and if the threshold was not possible to be determined, the set of data should not have been discarded. There are other signs, i.e. the PETO2 and PETCO2 as well as the time course of RER that could help. It is important to realize that ALL of

these have to agree pointing to the LAT. These are just different signs of the same physiological changes as a response to metabolic acidosis.

***Our reply**: Thank you for your valuable comments.*

We used either the breakpoint from the $\dot{V}CO_2$–$\dot{V}O_2$ relationship (V‑slope method) or the ventilatory equivalents method *to determine the threshold. We revised this section in Line 64-66.*

The LAT was identified by the non-invasive method described by Beaver and colleagues (18), which clearly identifies the breakpoint from the $\dot{V}CO_2$–$\dot{V}O_2$ relationship (V‑slope method) or by the ventilatory equivalents method (19, 20).

- The reference (19) should be given at the first occurrence of GPAQ

***Our reply:** Thank. We repositioned the reference # 16 for GPAQ citation.*

Page 6:
- Again, you MUST define how the plateau was assessed. I am sure it was based on the Breath By Breath data on the Vmax display, but somehow you MUST get to the definition. Based on the 30 sec average you simply just cannot do it.

***Our reply**: Thank you for your comment.*

VO2 plateau was based on the Breath-By-Breath data on the Vmax display that the fixed-width box of 20 s was exploited to select the VO2 at peak exercise. We agree that it is not a correct method as you mentioned, therefore we decided to take out this section.

- These are well-established signs of maximal exercise - however none should be used to INDICATE that the exercise SHOULD be stopped.
- On the other hand, if the exercise is stopped by indications of INTOLERANCE, these signs are usually show these values.

***Our reply**: We totally agree. We added the indications of exercise termination criteria (Line 55-57).*

We also used the criteria for the purpose of a retrospective review by one of the authors (PP.) to select the good-quality CPET results for analysis. (Line 67-70)

To determine the $\dot{V}O_{2peak}$, all CPET data were reviewed by an investigator (PP) and considered for analysis when all of the following criteria were met: 1) intolerable fatigue reported by the subjects, 2)

achieving HR_{peak} of ≥ 85% of the predicted value at the subject's age (220-age), 3) having an RER of ≥ 1.1 (1).

- Put the P value in parentheses if you write them into the text.

***Our reply**: We put the P value in the parenthesis in the text.*

- Did you analyze the VO2 at the LAT and at peak (VO2peak) as a function of activity? Was the VO2 at the LAT and at peak correlated with physical activity?

- If so, it would be nice to show

***Our reply**: Analysis of $\dot{V}O_{2peak}$ and $\dot{V}O_2$ at the LAT as function of physical activity level is shown in Figure 3 and the results are described in line 108-114.*

Page 7:
*- It would be nice to see the ratio of VE to the MVV (you had spirometry in all of them, therefore the indirect MVV could be calculated as FEV1*40. Can you compare these between age groups and sex groups? It would give a nice insight into the changes in 'ventilatory demand' if one exists. Alternatively, it would be nice to see if the ventilatory demand is not changing and individuals stop exercising at the same level of ventilatory demand.*

***Our reply:** Thank you for this excellent idea.*

We did analysed and compared VEmax/MVV (ventilatory demand) between age groups for both sexes. We did not see the differences of VEmax/MVV across the age groups in both sexes. This implies that the ventilatory demand is not changing across the age groups and individuals stop exercise at the same ventilator demand. (Line 173-175 and last 2 lines of table 2)

- Ventilatory equivalents section: Predictive equation paragraph needs to go under a different header (not Ventilatory equivalents.)

***Our reply:** We made a new heading for the predictive equations (Line 136-139).*

Page 8:
- Comment to value [1.795 (0.39 L.min-1]: I think this value for the Indian population might already be significantly lower than of the Thai males.
- Further down, 1.292 is for Indian females?

***Our reply**: Thank you for your comment. We agree for that observation and revise the content (Line 148-152); the mean (SD) values of VO2peak for Thai is comparable to those for Chinese but is higher than those for Indian in both sexes.*

Page 9:

- "Note that V'Epeak…": This cannot be stated unless the underlining power (work rate) is also considered. Therefore, the work rate should also be included in this discussion (or somewhere else).

- Be careful, because stating the VEPeak is smaller in Thai population, one might think that it is lower, because the Thai people need to breathe less - which is obviously not right.

***Our reply**: Thank you.*

We omit the sentence "the $\dot{V}_{Epeak}$ in Thai population seems lower than those reported from the Caucasian population" in the previous version of manuscript. Since the Thais had lower work rate than the Caucasians, our $\dot{V}_{Epeak}$ was definitely lower. The lower $\dot{V}_{Epeak}$ may not parallel with a systemic physiological deterioration.

- DETERIORATED? What do you mean? VE/VO2 and VE/VCO@LAT should be <~30 in both sexes. During rest and above the threshold VE/VO2 is higher - in fact, it is increasing without an increase in VE/VCO2 (as it is said when you determine the threshold). And so, deterioration needs a thorough explanation, what do you mean???
- Don't mix the VE/VO2 and VE/VCO2 (the ventilatory equivalents) with the VE/VCO2 slope. This latter one is the slope of the straight line on the plot of VE vs. VCO2 up to the respiratory compensation point (RCP).

***Our reply**: Thank you for your comment.*

We acknowledge that VE/VO2 and VE/VCO@LAT should be <~30 in both sexes. These values from the aged subjects are higher than those from younger age (mean values > 30 in the age group of 61-70 and 71-80). Therefore, we try to find the explanation from this observation by the work of Brischetto et al. (22) (J Appl Physiol Respir Environ Exerc Physiol. 1984 May;56(5):1143-50). We also took out the word "deteriorated" in the paragraph to avoid the misunderstanding.

Line 176-180

The $\dot{V}_E/\dot{V}CO_2$ during exercise was greater in older than younger subjects and postulated that the increased ventilation to maintain an isocapnic state during exercise seems to compensate for the reduced efficiency of gas exchange in aging lungs (22).

Page 10:
- '…our subjects had hypertension and diabetes mellitus … ' -- Not ALL of them, you must be careful to say this... if it is true, the population you have used is NOT healthy, but hypertensive and diabetic... ALL of them were like this? No, only a ???% of the whole population had either hypertension or diabetes.

***Our reply**: Thank you for your comment.*

We inserted the proportion in percentage for hypertension and diabetes in the discussion (Line 193-196) to stress that these subjects had no cardiovascular complications and medications that possibly interfere the CPET results.

Page 11, Table 1.:
- The statistical test providing the P value for a frequency analysis should be stated.

***Our reply**: We added " *P value for a frequency analysis" at the footnote of table 1.*

Page 12, Table 2:
- This table MUST have Peak Work Rate values. Without work rate, the maximal values cannot be compared! If you do, the conclusion is going to be misleading!!!

***Our reply**: We provided the peak work rate values in table 2 in both sexes.*

- Last two lines of Table 2 males and also females: Are these Ventilatory Equivalents measured at PEAK exercise or at the THRESHOLD? This should be stated - I think both should be listed here (the VE/VO2 nadir and VE/VCO2 nadir - lowest point (which, for the VE/VO2 probably is at the threshold).

***Our reply**: We stated that the ventilatory equivalents for oxygen and carbon dioxide were measured at the LAT in table 2.*

Table 3:
- Again - the Ventilatory Equivalents are smallest at the threshold (these values should be stated and the regression equation should also be dealing with the smallest point! That makes more sense.

***Our reply:** We stated that the ventilatory equivalents for oxygen and carbon dioxide were measured at the LAT in table 3. The regression equations for both variables are derived from the value at the LAT which should be the smallest point.*

Page 19:
- Consider reporting the Standard Error of Estimate values for all regressions. That is the parameter that is most useful in seeing the accuracy of the prediction.

***Our reply**: Thank you for your comment. We reported the values of standard error of estimate for all regressions.*

Page 20:
- Scatter plots! (not scattered…) - Something is strange with this: it should be V'O2peak

***Our reply:** We changed scattered plots to scatter plots.*

Page 23:

- Scatter plot
- V'Epeak
- V'E/V'CO2

Our reply: *We changed scattered plots to scatter plots.*

Page 24:
- Scatter plot
- V'O2peak
- V'O2 at VT1 (or better yet, at LAT (!)

Our reply: *We changed scattered plots to scatter plots.*

OPEN PEER REVIEW

Revision (1)

Here, you can see the **Reviewers**, **Associate Editors** and **EICs'** comments from the beginning to the end of the revision process.

REFEREE: Reviewer | **Revision** (1) 23 Apr 2020

Dear AE,
Thanks to the authors doing significant additional work, statistics, and working on the text of their manuscript. All these mean additional value to the work. Thank you. I am satisfied with the responses and the work they put in this revision.
Thanks.

REFEREE: Associate Editor | **Revision** (1) 23 Apr 2020

Dear EIC
Based on the authors' answers to the reviewers' comments, the reviewer(s) have recommended publication.
Kind regards.

REFEREE: EIC | **Revision** (1) 24 Apr 2020

Dear Author,
The second round of peer review of your manuscript has been completed, and I am pleased to inform you that your manuscript has now been accepted for publication in our journal.
Thanks.