

## Authors' reply

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We thank Jun Watanabe for his interest in our study [1]. As stated in our protocol, our study followed the Preferred Reporting items for Systematic Review and Meta-Analyses (PRISMA) guidelines [2]. We predefined our study hypothesis and carried out a detailed systematic search with the assistance of an expert librarian. Since our meta-analysis involved only randomized clinical trials (RCTs), we used the Jadad scale to assess the quality of these studies [3]. To assess the quality of evidence, the Grades of Recommendation, Assessment, Development, and Evaluation (GRADE) approach is recommended [4].

In this approach, direct evidence from RCTs starts at high quality and can be rated down based on risk of bias, indirectness, imprecision, inconsistency (or heterogeneity) and/or publication bias, to levels of moderate, low, and very low quality. According to our analysis of the quality of the evidence, while there was no evidence of publication bias, the evidence was rated down for inconsistency, imprecision, and the risk of bias due to the unblinded nature of right and left lateral colonoscopy trials. Therefore, we concluded that while our meta-analysis shows no difference in right vs. left lateral colonoscopy with regard to the rate of cecal intubation or cecal intubation time, this is based on a low quality of evidence.

To date, our study included the largest cohort of patients in which right and left lateral positions for colonoscopy were compared specifically. We appreciate the author drawing our attention to other positions (i.e., supine, tilt-down, etc.) and referencing his study, which attempted to use meta-analytic

tools to compare four different positions for colonoscopy [5]. However, in this study each position had only 2-3 studies for pooled analysis. This raises a question regarding the necessity of performing meta-analyses with very small sample sizes.

## References

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