RESPONSE LETTER / ANSWERING REVIEWERS

May 13, 2015

Dear Editor,

Please find enclosed the edited manuscript in Word format (file name: EFTR Review WJG Revised_2_Changes_tracked.doc)

Title: Endoscopic full-thickness resection: current status

ID: 01445854; Manuscript revision NO: 18071

The manuscript has been improved according to the suggestions of reviewers:

1.) Reviewer No. 02823705:

- Introduction
    1. The abbreviation EFTR was now defined in the introduction.
    2. The history of EFTR, mainly starting with the FTRD prototype in 2001 was now mentioned in the introduction.
- Methods/Indications
    1. The indications for EFTR in the colorectum, especially in case of non-lifting lesions have now been extensively described in the revised manuscript.
- General Principles
    1. Thank you for this excellent and interesting comment. It is of course correct that NOTES research has clearly demonstrated that abdominal infection during transgastric interventions is not a relevant clinical problem. However, data on transcolonic interventions is limited and risk of bacterial seeding was suggested to be higher for this access route. This of course does not necessarily result in relevant clinical infection. However, in our view, there is no reason to risk peritoneal infection by creation of a colonic wall defect with subsequent defect closure when a simple one-step closure-and-resection device (like the FTRD) is available. We have modified the section in the manuscript, acoordingly.
- Limitations
    1. More information about the mentioned prospective studies was added

2.) Reviewer No. 00044980

1. A table showing advantages and disadvantages of the different EFTR techqiques has been added.
2. Spelling and grammatical errors have been corrected.

3.) Reviewer No. 00253974

- The search queries were now included in the methods section
- All abbreviations are now explained when firstly used in the manuscript
- The introduction was modified and the history of EFTR was explained using the probably most important innovation (OTSC-Closue, FTRD) as an example. We have also tried to make clear that the most important issue qualifying EFTR for clinical routine is a secure closure mechanism (see also general principles of EFTR), good endoluminal manoeverability and a certain degree of "user-friendliness". The best example for this again ist the FTRD which is commercially available and already nearly routinely used by many interventional endoscopists in Europe.
- The indications for EFTR are now intensively discussed in the revised manuscript. Furthermore, it was stated that „Although not yet clinical routine, all mentioned indications are already applicable in clinical practice with existing EFTR techniques and devices"
- Section General principles of EFTR: „With „modern closure techniques", we especially meant OTSC which is currently probably the best broadly available method for perforation closure. We did not state that there were "numerous closure techniques under development, not suitable yet for clinical use".
- Section Gerneral principles of EFTR: we stated that „Several studies investigating non-insufflation techniques and countertraction devices/platforms have addressed this problem, but all devices are still at the stage of prototypes and far away from clinical use". For further explanation we kindly refer to the section "EFTR with subsequent suturing". Here we stated: "Mori and colleagues demonstrated the experimental use of a Double-arm-bar Suturing System (DBSS) to close gastric defects after EFTR21. …. It is noteworthy, that all interventions with the DBSS were done without air/CO2-insufflation, a mechanical countertraction device was used to maintain an operative field. Both the countertraction device and the DBSS are still in the stage of early prototypes and

are not clinically approved". The according paper by Mori and colleagues which was of course cited in the manuscript.

- The figure descriptions have been edited accordingly.

4.) Editorial Office:

- We have not sent the revised manuscript to a professional English language editing company because the corresponding author Prof. Dr. Caca is a native speaker
- An audio file with the core tip summary was added
- The references were re-formatted including all authors and DOI/PMID numbers