Dear Mr. Wang:

Thank you for your letter and for the reviewers' comments concerning our manuscript entitled "Successful treatment of obstructing colonic cancer by combining self-expandable stent and neoadjuvant chemotherapy: A case report and literature review". The constructive comments from the reviewers are very helpful to improve the manuscript. We have studied those comments very carefully and have made correction which we hope meet with approval. The main corrections in the paper and the response to the reviewer's comments are as following:

Comments:

A: Performance status and comorbidities of the particular patient should be mentioned. SEMS insertion carries its own morbidity and relevant tecnical issues and complications should be reported in the Discussion.

B : 1. "According to the guideline of ESGE, the patient should have surgery 5-10 days after stent insertion" Could you explain it in more detail? Why should the patient have surgery 5-10 days after stent insertion? If having surgery less than 5 days or more than 10 days after stent, what problems would it cause to the patients? Is there any evidence against having surgery more than 10 days (even more than 50 days) after stent? 2. Please provide more references, such as"because of the chronic obstruction, the swelling of intestine is common, and the patients usually suffer from malnutrition, electrolyte disturbances and some other disorders. Stoma rate and complication rate are high in surgically treated patients". 3. In the discussion, you mentioned that the patient's intestine was very swollen at admission. And the patient was in a poor nutritional status. so you did not perform the operation on the patient at once. But you also mentioned "Recent studies indicated that there was no difference in progression-free survival (PFS) and overall survival (OS) between emergency surgery and stent placement. More importantly, some studies reported that the endoscopic stent insertion for colorectal cancer may result in tumor cell dissemination into the peripheral circulation and may induce distant metastases and poor prognosis." This was also one of the reasons why you did not perform the operation on the patient at once. I really get confused. 4. In the discussion, you mentioned "it reduces the stoma placement rate as well". It just a case-report, how can you conclude that it reduces the stoma placement rate? 5. Please explain the clinical value of this case in more detail. In addition, in the reference "Self-Expandable Metal Stents for Colorectal Cancer: From Guidelines to Clinical Practice", the article has reported three patients who underwent neoadjuvant chemotherapy in the bridge to surgery group.

C: This manuscript provides the useful information for readers.There are some comments to increase the perfection of this manuscript.Please describe the information of CT nodal staging before stent and after neoadjuvant therapy.In the discussion, please add your opinion about

optimal duration of neoadjuvant therapy.Perioperative 12 cycle mFOLFOX regimen is preferred treatment in NCCN guideline. Please describe the reason of 8 cycle chemotherapy (neoadjuvant 2 cycle plus adjuvant 6 cycle).

Response:

Reply to Reviewer A:

We thank the reviewer for the constructive criticisms that have helped us to improve our manuscript. We have added the conditions about performance status and comorbidities of the patient in the part of case presentation and discussion(written in red). The correction about SEMS was added in the discussion (written in red).

Reply to Reviewer B:

Thank you for the constructive comments. The corrections are as follows: 1. In Ref. 11, there was a paragraph about the time interval to operation: "There are limited data to determine an optimal time interval to operation following stent placement as a bridge to surgery. Theoretically, a longer interval (>1 week) will allow for better recovery and more nearly optimal nutritional status, but this may increase the risk of stentrelated complications and may compromise surgery by more local tumor infiltration and fibrosis. Therefore we suggest a 5- to 10-day interval between SEMS and elective resection. Data from the abstract of one RCT (n = 49) published in Chinese, which compared laparoscopic resection 3 and 10 days after stent placement, reported a significantly higher primary anastomosis rate and a lower conversion rate to open procedure when surgery was deferred until 10 days after stenting. A retrospective analysis revealed an anastomotic leakage rate of 20% (3/15) for an interval of 1 to 9 days and 0% (0/28) when surgery was delayed for 10 days or longer (P = 0.037). A published abstract comparing resection within 7 days (n = 26) and after 7 days (n = 30) of stent placement, found no differences in the postoperative morbidity and mortality. In the literature, a median time interval to surgery of 10 days is a common practice considering the patient's clinical condition, potential risk of stent-related complications, and impact on oncological outcomes". **And we have added the description in detail about the interval in the discussion. 2. We have added some references (Ref.1,2). 3. I'm sorry that you get confused about what I said. We have revised the sentences and we hope that can make you satisfied. 4. In nearly one year, we have treated more than 10 cases like this. The treatment pattern is a clinical trial (NCT 02972541) that we are performing. The aim of this clinical trial is to evaluate whether this treatment pattern is better than other treatment patterns. 5. In the discussion, we have added some description about the clinical value.**

Reply to Reviewer C:

Thank you for the constructive comments. The corrections are as follows: 1. we have added the information of nodes before stent and after neoadjuvant therapy (written in red). 2.we have added the information about the optimal duration of neoadjuvant therapy (written in red). 3. I am sorry that we didn't explain that we have changed the regimen after operation. Because when the patient was admitted to hospital, the patient could not eat or drink, so we chose the mFolfox. After the operation, we changed the regimen to Xelox, and they are both the first-line chemotherapy regimens.