

Dear Dr Dou,

Thank you for the positive feedback. We have carefully reviewed the valuable comments from the reviewers. We have tried our best to revise manuscript according to the comments and updated journal guidelines. Some inappropriate phrases and expressions have been modified. Revised portions are marked in red in the revised manuscript. Our point to point responses to the reviewer's comments are as follow. Responded portions are marked in blue and underline.

Response to Reviewer's comments:

Reviewer 1 (ID: 02537436):

1. I wonder whether the patient without metastasis is ethically acceptable if stent placement causes higher recurrence or inferior survival. Because we have an alternative method such as transanal ileus tube to reduce intraluminal pressure.

Response: Thank you for your comment. Patients with acute obstruction, no matter with or without metastasis, can avoid emergency surgery and have low complications and stoma creation rate after stent placement. The benefits after stent placement as a bridge to surgery outweigh its potential inferior oncologic results. In addition, the patients were arranged subsequent chemotherapy, not stent placement alone. Stent placement followed by chemotherapy would not cause higher recurrence or inferior survival. So, we think it is ethically acceptable.

The purpose of stent insertion or transanal ileus tube is to transform emergency surgery to elective surgery. Each method has its own advantages and disadvantages. The reasons we favored stent are as follows. First, some studies showed that stent placement can achieve quicker decompression or greater resolution of histopathologic edema or higher laparoscopic surgery rate than after placement of transanal tube. Second, transanal ileus tube is not suitable for the arrangement of subsequent chemotherapy. At last, clinical

evidence comparing oncologic outcomes between the two methods is lacking: As far as we know, there is only one paper (Takahashi G et al. PMID: 29235008. doi: 10.1245/s10434-017-6300-x) which showed increased oncological risk of stent placement than in terms of molecular analysis.

2. Please confirm the institutional review board approval and written informed consent.

Response: We are sorry that we did not state the institutional review board approval. We have added the institutional review board statement on the title page. Before written informed consent, we have explained to patients that the purpose of preoperative chemotherapy after stent placement is to eliminate the potential negative effect. The study was reviewed and approved by the Ethics Committee of our hospital. (Line 19-21, Page 1)

3. Please comment Roman numerals in table 1, tumor stage, clinical stage or other.

Response: Thank you for your comment. We are sorry for the unclear description of tumor stage. The tumor stage in table 1 is the pathological stage. After listening to your valuable suggestion, we consider clinical stage before chemotherapy is more appropriate than pathological stage in terms of representing the basic characteristics of patients and guiding treatment choice. Besides, preoperative chemotherapy may down staging tumor. We have corrected with clinical stage before chemotherapy in Table 1. (Line 1-6, Page 12) The comparison between clinical stage before chemotherapy and pathological stage after surgery is shown as below.

Clinical stage before chemotherapy	
Characteristic	Data (N=6)
Tumor site	
Descending colon, III	1 (16.7%)
Sigmoid colon, III	1 (16.7%)
Sigmoid colon, III	2 (33.3%)
Sigmoid colon, IV	1 (16.7%)
Rectum, II	1 (16.7%)

Data are n (%).

Pathological stage after surgery	
Characteristic	Data (N=6)
Tumor site	
Descending colon, III	1 (16.7%)
Sigmoid colon, II	1 (16.7%)
Sigmoid colon, III	2 (33.3%)
Sigmoid colon, IV	1 (16.7%)
Rectum, II	1 (16.7%)

Data are n (%).

Reviewer 2 (ID: 03270441):

1. A clinically meaningful paper. Authors introduced a novel compressive regimen for the patients with acute malignant colorectal obstruction (AMCO). This regimen achieved good results for all these six patients. From the paper this new method may be warranted to further study for AMCO.

Response: Thank you so much for your encouraging review and suggestion.

2. However, there were three issues should be noticed: First, why acute adverse events were evaluated according to the CTC AE Version 3? CTC AE4.03 has been widely used for at least the past 5 years. And the CTC AE V 5.0 is available now.

Response: Thank you for your suggestion. We have revised the evaluation method with CTC AE 4.03. (Line 26-28 Page 6)

3. Second, the recruitment of the 6 cases were not mentioned in the manuscript.

Response: We are very sorry that we did not state this in the manuscript. We have added the recruitment criteria and the exclusion criteria of the 6 cases in the beginning of "CASES PRESENTATION", and we revised this section with subtitles according to the editor's requirement. In addition, we added the initial level of BMI, hemoglobin (Hb), albumin (Alb) and creatinine (Cr)

during the first hospitalization in Table 1. (Line 1-6, Page 12)

4. Third, any words such as "safe anastomosis" should be modified.

Response: We are very sorry for this mistake. Thank you for your careful review. We have revised the phrase "safe anastomosis" and used the phrase "primary anastomosis". (Line 16, Page 4; Line 19, Page 7; Line 14, Page 9)

Reviewer 3 (ID: 03017458):

1. Congratulations to the authors of successful work. Foreword could say article could be published after minor revision.

Response: Thank you for your encouraging comment.

2. It clearly needs to be removed phrase "literature review" from the title. Literature review can not consist of 18 references.

Response: Thank you for your advice. We have revised the title and deleted the phrase "literature review". (Line 3, Page 1)

3. Phrase "There was 1 patient with descending cancer, 4 with sigmoid cancers and 1 with rectal cancer" should move to the beginning of section "case series".

Response: Thank you for your valuable advice. We have moved the sentences to the section "FINAL DIAGNOSIS". (Line 26-30, Page 5)

4. Finally, applying of neoadjuvant chemo between stent placement and surgery in patients with acute malignant colorectal obstruction it is a novel strategy without any strict recommendations regarding number of chemo cycles. Authors "According to experience" selected two cycles of FOLFOX chemo which "have acceptable toxicity and patient compliance". Such a strategy could improve oncological outcomes but needs confirmation in clinical trials.

Response: Thank you for your detailed comment. We completely agreed with your comment. The optimal cycles between stent placement and surgery and will be controversial, and the oncological improvement of this strategy needs confirmation in clinical trials. So, we have revised the manuscript in the "EXPERIENCE AND LESSONS" section of study: "However, the oncological

improvement of this strategy and the optimal cycles of preoperative chemotherapy need confirmation in further studies, in particular clinical trials”
(Line 3-5, Page 10)

5. But 2 of 6 patients of this series had liver metastases. 2 cycles of FOLFOX it is clearly not enough for neoadjuvant chemo to inspire regression of metastases and improve survival. Presens of effective stent allow to perform more cycles of chemo.

Response: Thank you for your comment. First, although the two patients had synchronous liver metastasis, they were suitable for curative resection. One patient had two metastatic site respectively in S2 and S4 and received partial hepatectomy. The other patient had one metastatic site in S8 and underwent microwave ablation. So, the regression of the metastasis in liver was not our main purpose of arranging two cycles of chemotherapy in these selected patients. The main purpose is to eliminate the tumor dissemination and obtain better surgical results. Futhermore, partial hepatectomy or microwave ablation was carried out after primary tumor resections. Second, long time with stent placement might induce complications such as reobstruction, stent migration and perforation, particularly for chemotherapy during stent placement. We favored two cycles of neoadjuvant chemotherapy, because some patients in our centers who were arranged with three or four cycles of chemotherapy had some complications, relatively low patient compliance and increased surgical difficulties. However, the number of cases is limited. We completely agreed with you that it needs further studies and more cases to confirm. We revised the manuscript in the end of “Discussion” section: “In our study, the two cycles of preoperative chemotherapy have excellent clinical outcomes and patient compliance. However, it needs further studies to confirm.” (Line 21-24 , Page 9)

6. Therefore, this article could be published after revision in section "Case report".

Response: Thank you so much for your encouraging review.