Reviewer #1:

Comment 1: In several short-term outcomes, the corresponding literatures are lacking i.e. MAEs, perforation, postoperative bleeding.

Response: We supplemented the corresponding literature on short-term outcomes (manuscript page 4, lines 11-12).

Comment 2: If PS matching was performed, Table 1 should show not only the P-value but also Standardised Difference.

Response: We supplemented the standardized mean difference in Table 1 (manuscript Table 1).

Comment 3: ESD in this study was performed by the same endoscopist, and it is noted that the same-day discharge strategy has been performed since 2020. Is it possible that the surgeon's skill has improved and there was no difference in major adverse events between a same-day discharge group and a multi-day discharge group? Why not do an additional study with only cases from 2020?

Response: One of the limitations of our study was that all of the procedures were performed by a single skilled endoscopist with 14 years' experience in gastrointestinal ESD, and our experience reflected that of a high-volume center with a specialized endoscopist to perform ESD. Thus, our results might not be applicable to other centers. A further investigation involving more endoscopists, with varying degree of experience, from more centers, with diverse structure, is being designed and planned, and we hope to provide more conclusive findings in the future. (manuscript page 12, lines 8-14).

Comment 4: What was the rehospitalization rate within 7 days of discharge in the same-day discharge strategy group? What were the risk factors?

Response: No rehospitalization was needed within 7 d of discharge in either group. (manuscript page 9, line 5).

Reviewer #2:

Comment Major 1: Title: I wish the title were more straightforward. Wouldn't feasibility or safety be better than the word 'strategy'? I hope the authors take

this into account.

Response: Thanks to the reviewer's suggestion, we have changed the title of the manuscript to make it more straightforward (manuscript page 1, lines 6-7).

Comment Major 2: The introduction section was too short. Please provide more information on background and evidence to guide the research hypothesis. Also, separate the study aim as a new paragraph (last paragraph of the introduction section).

Response: We provide more information on background and evidence to guide the research hypothesis (manuscript page 4, lines 10-18). And we have separated the study aim as a new paragraph (last paragraph of the introduction section).

Comment Major 3: Please provide the IRB number and ethic statements in the Method section.

Response: We provide the IRB number and ethic statements in the Method section (manuscript page 5, lines 1-2) and the Footnotes.

Comment Major 4: How about changing the word 'complete resection' to 'curative resection.' Those two words are different, and I think the authors use the complete resection as a curative resection.

Response: Achieving tumor-free margins is essential for the efficacy of ESD in early gastrointestinal malignancies (manuscript page 11, lines 6-7). In this study, we evaluated the complete resection rate in both groups. Complete resection was defined as resection of a tumor without histological evidence of tumor cell involvement on the lateral and vertical resection margins (manuscript page 6, line 9-11).

Comment Major 5: The authors provided the p-value after matching. Please present the SMD values in the table. In PSM, the p-value doesn't matter.

Response: We supplemented the standardized mean difference in Table 1 (manuscript Table 1).

Comment Major 6: Because the authors compared the two groups after PSM, the comparison before matching is meaningless. Therefore, delete the

comparison before matching in the second paragraph of the Result section (subtitle: clinical outcomes of ESD). If you want to show the data before PSM, please create a separate paragraph and describe it.

Response: We have deleted the comparison before matching in Table 2 and Table 3, and the second paragraph of the Result section (subtitle: clinical outcomes of ESD)

Comment Major 7: The authors showed the lesion in the lower third of the stomach was risk factor for postprocedural bleeding. The OR was 8.065. That was too high. Previous study (World J Gastroenterol. 2010 Jun 21; 16(23): 2913–2917.) reported that, OR of the lower third of the stomach was about 2.00. I think OR 8.065 was too high. What percentage was the lower third of the stomach in the total lesion? Present these numbers in Table 1. Clinically, bleeding from the cardia and fundus is more frequent than from the antrum during ESD. Of course, delayed bleeding can be different. Even considering this, the OR in this study was too high. The authors should further explain this in the discussion section. Bile reflux and peristalsis are challenging to explain.

Response: We supplemented the percentage of the upper, middle and lower third of the stomach in Table 1. And also, we added the odds ratio of the lower third of the stomach, and recalculated the odds ratio of the lower 2/3 of the stomach as risk factors for postprocedural bleeding (Table 5). Tumor in lower third of stomach was the independent risk factor for post-ESD bleeding [World J Gastroenterol. 2010 Jun 21; 16(23): 2913–2917.]. In our series, a slightly higher incidence of postprocedural bleeding (6.0%) was noted in the stomach, whereas mid- to lower location in the stomach was identified as the only risk factor for postprocedural bleeding, suggesting that we should not only pay attention to the lesions in the antrum but also those in the angle and gastric body to minimize the risk of postprocedural bleeding.(manuscript page 9, lines 28 - page 10 line 4). Active antral peristalsis as well as bile reflux might lead to a higher incidence of post-ESD bleeding [Gastrointest Endosc Clin N Am 2021; 31(3): 563-579] (manuscript page 9, lines 30-31).

Comment Major 8: Unfortunately, ESD was performed with a single operator. I think it would have been better if the operator factor was put into a variable and matched. Please add this issue in the limitation section.

Response: One of the limitations of our study was that all of the procedures were performed by a single skilled endoscopist with 14 years' experience in gastrointestinal ESD, and our experience reflected that of a high-volume center with a specialized endoscopist to perform ESD. Thus, our results might not be applicable to other centers. A further investigation involving more endoscopists, with varying degree of experience, from more centers, with diverse structure, is being designed and planned, and we hope to provide more conclusive findings in the future. (manuscript page 12, lines 8-14).

Comment Minor 1: Please use the entire term 'hemoglobin' instead of HGB.

Response: We have changed 'HGB' to the entire term 'hemoglobin'.

Comment Minor 2: In the Method section 4th paragraph, please provide the reference of definition for complete resection. As mentioned above, if what the author means is a curative resection, it is recommended to change the word.

Response: Achieving tumor-free margins is essential for the efficacy of ESD in early gastrointestinal malignancies (manuscript page 11, lines 6-7). In this study, we evaluated the complete resection rate in both groups. Complete resection was defined as resection of a tumor without histological evidence of tumor cell involvement on the lateral and vertical resection margins (manuscript page 6, line 9-11).

Comment Minor 3: In Figure1, the box of excluded, what did it mean the lesion in gastric remnant? Does it mean non-complete resection? Please clarify this.

Response: We apologize for the confused expression. And we have changed the term 'gastric remnant' to 'a history of esophagectomy or gastrectomy' (manuscript page 4, lines 30-31; Figure 1).

Comment Minor 4: Table 1, please provide the information on specific tumor locations in the stomach and esophagus, respectively (upper 3/1, middle 1/3, and lower 1/3).

Response: We have provided the information on specific tumor locations in the stomach and esophagus, respectively (upper 3/1, middle 1/3, and lower 1/3) (Table 1).

Comment Minor 5: Table 5, Please provide the OR as one decimal point.

Response: We have provided the OR as one decimal point (Table 5).

Revision reviewer

Comment: For this article, I have no special questions

Response: Thanks for your comments.

After the revision of manuscript according to the reviewers' comments, we would like to re-submit this revised manuscript to ***World Journal of Gastroenterology***. We hope that these responses could clear up reviewers' concerns and the revision could meet your expectation.

Looking forward to hearing from you soon.

Yours Sincerely,

Qi Wu,

Email: wuqi1973@bjmu.edu.cn