

Dear editor and reviewers,

First of all we would like to thank you for your interest and dedication in reviewing the document, and for your constructive comments and suggestions. We really appreciate it. We are confident that with this new version our work has clearly improved. Here we answer to the questions and suggestions.

Reviewer 1:

Specific Comments To Authors:

In this work by Gonzalez-Lama et al, the authors address the important topic of medical consultation in ulcerative colitis. The work is written in appropriate English language and it is clear and concise in the topics that it tackles.

1. I suggests adding a paragraph (and also a summary in table 2) on consultation for male/female patients with regard to fertility and pregnancy in IBD, referring to the newest ECCO Guidelines (<https://doi.org/10.1093/ecco-jcc/ijac115>)

Thank you for the suggestion, we fully agree with you. Therefore, we have added this paragraph in the text and a summary in table 2. Similarly we have referenced the newest ECCO Guideline.

Text: "In this context, it vital to address, in male and female patients sexuality issues and conception which, in order to optimize pre-conceptional, pregnancy and post pregnancy counselling, including the monitoring and therapeutic management of these patients".

Table 2: "Assess sexuality and fertility issues" and "Assess pregnancy desire: e.g. when informing about drugs".

2. At page 7, the authors state "Reliable sources on the Internet should also be offered". Please expand this part with more details. - in many sentences throughout the paper, I feel that references are missing regarding what is actually stated. Particularly for psychology, feelings of patients etcetera, are all these information provided coming from surveys? Original articles? It is important to give literature evidence of all statements.

Thank you for the observations. You are right.

The Internet is full of information about the disease, but much of it is many times inaccurate even false, which might produce a negative impact on patients. For this reason, we consider it very important to show patients reliable on-line sources of information such patient associations or scientific societies websites. We have explain it in the text.

Most of the information is based on qualitative studies such as patients focus groups, consensus documents or surveys. But there are also some original articles describing the effect of different interventions like motivational interviewing. He have reviewed the text and added more references.

3. A conceptual question would also be: why focussing only on UC instead of giving a general overview of IBD, so considering also Crohn's disease?

We agree with you, at least in part. This article is part of a larger project in which different specific aspects of ulcerative colitis have been assessed based on the differential aspects of the disease. However, most of the concepts and recommendations of our work can be also applied

to patients with Crohn's disease. Thus, we have included this statement in the introduction: "Although this work is focused on UC, most of the results can be applied to patients with other types of inflammatory bowel disease".

Reviewer 2:

Specific Comments To Authors:

The manuscript "Medical consultation in ulcerative colitis: key elements for improvement" addresses important issues in the clinical communications between patients and healthcare providers.

1. It is for certain that the vast majority of guidelines focus on the hard-science of IBD and the principles of medical management. While the clinical scenarios are well thought of and summarised in Table 2, the principles and practice points do appear too generic. Many of the pointers such as empathy and open questioning are very generic and can be said of any clinical consult not unique to IBD alone.

We agree with you to some extent. We recognize that some principles and practice points might result too generic, but we also consider that this is the starting point, specially taking into account patient's perception of daily care and reported unmet needs. On the other hand, as there have been published different articles (most of them consensus documents based on the best evidence available) describing these points in detail, we have included in the document. Here some of them:

1. Casellas F, González-Lama Y, Ginard Vicens D, García-López S, Muñoz F, Marín Sánchez L, Camacho L, Cabeza A, Fortes P, Gómez S, Bella Castillo P, Barreiro-de Acosta M. Adherence improvement in patients with ulcerative colitis: a multidisciplinary consensus document. *Rev Esp Enferm Dig* 2022; 114(3): 156-165
2. Barreiro-de Acosta M, Marín-Jiménez I, Panadero A, Guardiola J, Cañas M, Gobbo Montoya M, Modino Y, Alcaín G, Bosca-Watts MM, Calvet X, Casellas F, Chaparro M, Fernández Salazar L, Ferreiro-Iglesias R, Ginard D, Iborra M, Manceñido N, Mañosa M, Merino O, Rivero M, Roncero O, Sempere L, Vega P, Zabana Y, Mínguez M, Nos P, Gisbert JP. Recommendations of the Spanish Working Group on Crohn's Disease and Ulcerative Colitis (GETECCU) and the Association of Crohn's Disease and Ulcerative Colitis Patients (ACCU) in the management of psychological problems in Inflammatory Bowel Disease patients. *Gastroenterol Hepatol* 2018; 41(2): 118-127

2. I feel it would be of better value and relevance to the IBD physician, if the authors illustrate their pointers using a case scenario of a patient with ulcerative colitis at initial presentation, and to take the reader through the various stages of this patient's clinical journey (diagnosis, diagnosis disclosure after endoscopy , follow-up post treatment , monitoring control, addressing issues of colorectal cancer risk , compliance ; addressing concerns of therapy escalation/ need for colectomy). The authors can propose certain challenging scenarios or difficult communications with the patient; they can thereby suggest strategies how to approach these difficult communications ad verbatim. E.g. On the issue of topical therapy compliance, the patient says he cannot comply with nightly enema administration or that the enema tends to leak out. The authors may suggest how they would try to negotiate for the patient to comply ad verbatim: "Perhaps aim to use enemas 3 times a week first to get used to it? Perhaps if liquid enemas don't work, we can consider foam preparations that retain better? " Similar ad verbatim communication points can be done for the section of switching/escalating therapies , communicating cancer risk and need for dysplasia screening ,

new extraintestinal manifestations. The patient is concerned that he may need a colectomy if he runs out of therapeutic options with even second-line biologics. How would the authors suggest one approaches this situation ? If one is failing multiple biologics, should the consultation with a surgeon and a stoma nurse be made early ? How do the authors suggest the issue of potential surgery/pouch creation be brought up during the consultation ? Benefits versus risks ? Potentially curative for UC ? Risks - stoma complications ? pouch complications ? reduced fecundity ?

We also agree with you and this is a very nice and appropriate suggestion, thank you very much. In fact, your idea even deserve another article/project to better illustrate all of the concepts that we have arisen. But we also believe that this should be performed in a separate project in order to illustrate everything with full detail. There are many clinical scenarios that could specifically be described following the history of a patient. Besides, as we have previously mentioned, some of the publications that we have been included in our work assess these aspects more deeply.