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Acetic acid chromoendoscopy: Improving neoplasia detection in barrett's esophagus

Response to reviewer comments:

Reviewer 03317135:

We thank you for your kind review of our article. (1) We have now detailed the endoscopy equipment used in both Figure 1 and Figure 2. (2) Many thanks for suggesting additional references to be included for the introduction. We read with great interest the paper on technical skills and training of upper gastrointestinal endoscopy for new beginners, but we feel that as there is no reference to Barrett's esophagus or chromoendoscopy in the paper it would be difficult to include in our manuscript. The case report of ectopic sebaceous glands in the oesophagus was extremely interesting, but as the authors of the paper conclude "*This lesion should be sometimes differentiated from other oesophageal lesions such as granular cell tumour, xanthoma, papilloma, glycogen acanthosis and candida infection. Thus, greater attention is needed for detection and differential diagnosis of these lesions.*" we feel there is no direct relevance to our paper on acetic acid chromoendoscopy for Barrett's esophagus and have therefore, been unable to include it in our references. (3) The paper has been carefully re-read by all authors to identify and correct grammatical and typing errors. We appreciate your decision to accept the manuscript for publication and your kind comments that you feel it will be a widely cited article.

Reviewer 02998373:

Many thanks for your thorough review of our manuscript, your comments will undoubtedly improve the quality of our paper. We acknowledge our error in the abstract and have modified accordingly. We have added the reference from Sturm and Wang's review in Gut last year. We have added the word "gastroesophageal" before "reflux." We have modified the references to include only one reference for the SURF trial. We have rephrased the statement "the vast majority of Barrett's neoplasia is not visible on white-light endoscopy" to "With only 13% of early neoplastic lesions appearing as visible nodules, a significant proportion of Barrett's neoplasia is not visible on high-definition white-light endoscopy alone, with reported sensitivity in the range 40-64% and specificity 98-100%." We have corrected from Seattle 4QBs every 1cm to Cleveland clinic protocol 4QBS every 2cm. With reference to concentrations of acetic acid - there are no "dose titration studies" to identify the optimum concentration of acetic acid. Whilst there are a few studies using concentrations higher than 3% acetic acid a majority fall within the range 1-3%. Acetic acid leads to vascular congestion and it is our view that concentrations of acetic acid higher than 3% cause a little oozing from the mucosa and therefore, we would advocate <3% acetic acid. As there is no referenceable data with respect to this we have not specifically commented in the review article.

We have added further to the descriptions put forward by Guelrud et al. and included their evidence of which patterns correspond to histological aspects. We have decided not to include endoscopic pictures demonstrating this classification as they are available in the referenced text. We have deleted "with a ROC of 0.92".

We have given better sense to the phrase "In our view this is clinically not relevant when dealing with long-segment BE" with the addition of the following "as presence of specialized IM would not alter surveillance intervals." "that" has been added before "the index endoscopy was used". We have rephrased to the following "reported on their prospective study of 100 patients undergoing Barrett's surveillance, 13 of whom had neoplasia, using 3% AA and non-magnification endoscopy."

We have added an additional comment clarifying the importance/significance of the ASGE PIVI criteria. We have altered the statement regarding the paper in 2010 to reflect the reviewer's comments. We have deleted the repetition of the word "applied" in the conclusion section. We have changed the images in Figure 2 to better demonstrate the loss of acetowhitening effect. We have added the cost reduction of Cleveland clinic protocol versus Seattle protocol to Table 1.

Reviewer 00159367

Many thanks for your review and comments.

Reviewer 00057299

Many thanks for your kind review. 1. We have modified the third paragraph of introduction and changed Seattle to Cleveland clinic protocol. 2. We have described in more detail the ASGE PIVI criteria in the section "acetic acid in the detection and characterization of neoplasia" paragraph 10.

Reviewer 00068599

Many thanks for your kind review and positive comments.