Response to Reviewers letter

Dear Editor of the *World Journal of Gastroenterology*,

We kindly acknowledge your comments and would like to express our gratitude for your thoughtfulness in reviewing in detail our manuscript.

All the comments of the reviewers were addressed.

Reviewer # 1

"It has been proven that FC was the optimal fecal marker for monitoring disease activity in postoperative CD. FL offered modest sensitivity for detecting recurrent disease.1 The author concluded that postoperative FC and FL levels accurately predicted endoscopic recurrence in the presence of anastomotic stricture. This is a very interesting study. Minor concern This manuscript demonstrated that 48 patients presented an anastomotic stricture and 86% were asymptomatic. My concern is that is it necessary to perform the endoscopic balloon dilation in these asymptomatic patients? When the colonoscopy could not pass the stricture, other small calibre endoscope may pass through".

We have shown that asymptomatic patients with a high value of fecal markers have a high likelihood of endoscopic recurrence so endoscopy should be performed in order to provide adequate endoscopic evaluation and adjust or optimize medical therapy. Indeed, we think that this may be performed with a small calibre endoscope when it passes through. However, in our population all the strictures were very narrowed and not traversed by the available small calibre endoscope so it was not a viable option. According to our experience we think that endoscopic balloon dilation is frequently the

only option to access the neoileum but we agree that a small calibre endoscope would be a good first option when the stricture can be traversed.

Reviewer # 2

The article is not novel but is interesting. The major problem is that we do not know the drug history and Crohn's disease activity index of the patients. The message of the article would be if the CD is not in remission there is high risk of recurrence of stricture. This is not novel but has importance.

We assessed clinical disease activity on the day of endoscopic examination, according to the clinical criteria of the Harvey-Bradshaw Index (HBI). This index was chosen because it has proved to have a good correlation with the Crohn's Disease Activity Index (CDAI) [Vermeire S, Schreiber S, Sandborn WJ, Dubois C, Rutgeerts P. Correlation between the Crohn's disease activity and Harvey-Bradshaw indices in assessing Crohn's disease severity. Clin Gastroenterol Hepatol 2010; 8(4):357– 63] and it is a simplified, less cumbersome alternative to the CDAI, as it does not require a prospective seven-day data collection, and is more suitable for use in clinical practice. Clinically inactive disease was defined as an HBI of less than 5. In our study, 40 (83.3%) of the patients were in clinical remission (HBI<5) and 8 (16.7%) patients had mild disease (HBI 5-7).

Regarding drug history, 26 (54%) of the patients were under immunomodulator [azathioprine 24(92%); 6-mercaptopurine 1(4%); methotrexate 1(4%)] and 20 (42%) under biologics [infliximab 8(40%); adalimumab 12(60%)], of those 9 (19%) were under combination therapy. Seventeen (36%) patients were under 5-ASA (in all cases concomitantly with an immunomodulator, biologic or both).