

Dear Editorial Board of the *World Journal of Gastrointestinal Endoscopy*,

We thank you for your thorough, thoughtful, and timely review of our manuscript, “Transoral outlet reduction: outcomes of endoscopic Roux-en-Y gastric bypass revision in 284 patients at a community practice” (Manuscript No. 87262). We appreciate the feedback from your reviewers and have incorporated these suggestions into a revised version of our manuscript. Please see point-by-point responses to your review comments and questions.

We believe these changes have enhanced the clarity and presentation of our manuscript for your readership, and that this publication would be well received by a wide audience, given the growing enthusiasm for and interest in endobariatric therapies.

Kind regards.

**Reviewer #1:**

**Here are some of my tips:**

**1. Dilation of the gastrojejunal anastomosis (GJA) is the main cause of RYGB's post-operative weight recurrence and one of the mechanisms of TORe, so it would be better to include GJA in keywords.**

Thank you for this point. We agree. We have updated our keywords to include gastrojejunal anastomosis/GJA.

**2. Provide more specific data and statistics: When referring to RYGB's weight loss and recurrence rates, more specific data and statistics can be provided to increase the accuracy and credibility of the information.**

Thank you for this comment. It is important for our readers that we highlight this trajectory with greater detail and precision. We have revised the opening paragraph of our introduction to address this.

**3. The article “Five-year outcomes of transoral outlet reduction for the treatment of weight regain after Roux-en-Y gastric bypass” have shown that almost all of the patients with TORe stopped gaining weight 3 or even 5 years after surgery, and most of them showed clinically significant weight loss. Therefore, can we consider extending the measurement time of TBWL and EWL to 5 years?**

This is a great point, and we agree that it would be most helpful to have that degree of longer-term follow-up to achieve a more substantial understanding of the efficacy of TORe, especially as a therapy for a chronic, progressive condition. However, this will be an unavoidable limitation for this manuscript, regrettably. Our practice first started offering TORe in August 2020, limiting follow-up beyond 3 years. Additionally, though our practice offers unlimited medical and dietician follow up for patients after TORe, the vast majority do so for one year. Given the low number of follow-up available beyond 12 months, it was difficult to draw conclusions from this limited sample. We therefore included follow up to 12 months. We have added this to the discussion section as a limitation.

**4. Could you elaborate further on how community setting deal with complications after TORe surgery in large hospitals?**

Thank you for this comment. Our study showed TORe is safe, feasible, and successful in the community setting; however, to your point, complications can rise, and though rare, some of these are serious enough to warrant inpatient management. As such, it is ideal if a) patients know what symptoms or signs to be vigilant for, b) they have reliable access to their physician (or a knowledgeable physician) at all times, and c) the physician performing TORe in the community setting has privileges in a nearby hospital. We have amended our discussion to include this point.

**5. Could you design a learning curve or process of TORe for other community settings to learn from?**

Thank you for this question. Learning curve is a critical aspect of any novel endoscopic bariatric therapy. There is little published on this in TORe—except for a novel simulator technique from Brigham and Women's Hospital, which has proven to be a useful tool for reducing cases needed until competency for purse-string pattern. We have included this in the discussion section.

Of note, procedure duration for endoscopic sleeve gastroplasty has been a useful metric to gauge competency; however, in our experience, the variability of post-RYGB anatomy make this an unreliable measure in TORe, as there are aspects of anatomy that make performance of TORe generally and purse-string suturing specifically far more challenging (short pouch, flat outlet, lack of *en face* view of outlet), and these can lengthen procedure duration considerably even for a highly-practiced bariatric endoscopist. For this reason, we did not include this as an outcome assessed in this cohort.

**Reviewer #2:**

**1. Did the patients have barium diet examination?**

Previously, as part of our evaluation of anatomy to assess candidacy for TORe, we performed an upper GI series (fluoroscopic assessment) for any patient undergoing TORe whose RYGB occurred prior to 2006 to clarify anatomy. We subsequently discovered that this did not change management (all patients were ultimately deemed appropriate for RYGB revision), so we abandoned this practice to decrease pre-procedural work up for the patient and reduce radiation exposure. No patients underwent fluoroscopic evaluation of anatomy after TORe as part of our TORe practice.

**Reviewer #3:**

**1. Accept in present form.**

**Reviewer #4:**

**Dear author's I was pleased to review your article and I have the following comments:**

**1. In the section discussion it is mandatory to compare your results with the existing literature.**

Thank you for this comment. This is an important aspect of a thorough and balanced assessment of the current study and its context in the practice of TORe. Our third paragraph of the discussion has elaborated on this, including reasons why our outcomes are discordant with the published literature. We have added additional references to this paragraph. We suspect that, overall, this is related to purse-string technique, ablation of the gastroduodenal anastomosis, and longitudinal follow up.

**2. Please highlight the limitations of the study.**

Thank you for this comment. We have expanded the limitations section of our discussion.