Format for ANSWERING REVIEWERS

March 20, 2015

Dear Editor,

Please find enclosed the edited manuscript in Word format (file name: 14850-revised.doc).

Title: When and why a colonoscopist should discontinue colonoscopy by himself?

Author: Tao Gan, Jin-Lin Yang, Jun-Chao Wu, Yi-Ping Wang, Li Yang

Name of Journal: *World Journal of Gastroenterology*

ESPS Manuscript NO: 14850

The manuscript has been corrected according to the suggestions of the reviewers:

1. Format has been updated.

2. Revision has been made according to the suggestions of the reviewer 68308.

(1) The Kudo classifications of colonoscopy difficulty and colonoscopist level should be stated in a separate table
Answer: I have added two separate tables to explain the two different items. I am very sorry for ignoring these points.

(2) INTRODUCTION: The analogy of the "80 year old obese patient…" is inappropriate and should be deleted.
Answer: Thank you very much for your suggestion. I have deleted it.

(3) Did the colonoscopist's use Midazolam before the opioid? This is contrary to standard practice and the pharmacological basis that opioids should be given first.
Answer: Yes, you are right. I have corrected it in the paper.

(4) Sedation practice should be explained more clearly.
Answer: I performed the standard sedative procedure at our endoscopic center after counseling opinions from the anesthetists in our hospital, so I have added it in the paper. Thank you very much for your advice.

(5) Was scope guide used for any procedures? Or if not, please state so.
Answer: “scope guide”. If you mean the use procedures of variable stiffness scope/invariable stiffness scope, I should say that we have not such procedures at our endoscopic center. Many articles have reported that the variable stiffness scope (VSS) was superior to the invariable stiffness scope (ISS) in most of the colonoscopy insertions. When VSS was not introduced into China from Japan, only ISS was used at our endoscopic center. After VSS was introduced, only VSS was used

at our center.

(6) Was a variable stiffness scope used for any failed intubation?
Answer: No. In opinions of our colonoscopists, other examinations may be selected, such as enema with salt of barium. In fact, when VSS was not introduced into our center, no colonoscope of this kind was used for the failed insertion at our center. We advised the patient to other centers that have VSS. So, information about fixation, tortuosity, laxity and redundance was not available, and we cannot give the related assessment.

(7) Please provide detail of the adenoma detection rates for the colonoscopists and their withdrawal times if available. If this information is not available, please state so.
Answer: I am sorry that the details of this information cannot be available now. If you worried about the rate of the missed diagnosis due to the large number of colonoscopies, please see the answer to Question 4 put forward by the reviewer 504462.

(8) DISCUSSION: Change "toughest" to:" a challenging procedure". Is colonoscopy the most difficult? If you believe so, please reference this statement.
Answer: Thank you for your carefulness！ I have corrected it.

(9) DISCUSSION Para 2: Last sentence : Some if the….ileocecum" does not make sense, please delete this sentence.
Answer: Thank you very much for your suggestion. I have deleted it.

3. Revision has been made according to the suggestions of the reviewer 504462.

(1) This is the most important point. You mention “patients who had undergone the most difficult colonoscopic procedures (Grade C, Kudo’s difficult classification)”, however, this classification is not shown and the reference is a Japanese book that it is hard to get. Is it possible to know what this classification consists of?
Answer: I have added a separate table to explain difficulty classification. I am very sorry for ignoring this point.

(2) Also it would be great to know the Kudo’s colonoscopist level classification. This is to know the accreditation level needed for a 4th level colonoscopist
Answer: I have added a separate table to explain the colonoscopist level classification.

(3) You mention that there were exclusion cases due to “commonly-encountered factors for the incomplete colonoscope insertion…”. Can you mention, how many cases were in this group? And, if eventually they were re-scheduled? Or why were they excluded from any procedure at all?
Answer: The reason why we excluded those patients is that their incomplete insertions were not caused by the operative techniques of the colonoscopists but for other reasons mentioned in the paper, *e.g.*, obstruction of the colon by carcinoma, patients’ discomfort, insufficient colon cleansing, *etc*. Of course, all the excluded patients would be re-scheduled if permission could be obtained from the patients. If the patients underwent repeated insertions but still failed to have the colonoscope inserted into the ileocecum because of the factors of the operative techniques, those patients would

be included in this kind of study. So, I included those patients in this study and added these contents in the paper.

(4) 37,800 colonoscopes in almost 10 years by 3 colonoscopist is impressive, as it means that each one should be done 1,260 procedures per year, and almost 5 per day (excluding weekends, but not the holidays or other non-procedural days, which could augment this number). Is it possible to know if the last patient of the day was more likely to be discontinued? Maybe fatigue could be a factor.

Answer: In China, colonoscopy is a very common and routine examination. A 4th-level colonoscopist is mainly responsible for intubation into the ileocecum and observing important lesions, and other colonoscopists (mostly 1st, 2nd-level colonoscopists) are responsible for withdrawing the colonoscopes and observing the colonic lesions. So, "5 per day" or "1260 procedures per year" is a relatively small number for a 4th-level colonoscopist working at a teaching hospital in China. In this operating mode, the colonoscopists do not usually feel fatigue.

(5) Also, it is known that patients with an incomplete cleansing of the colon are more difficult to complete, and even though you mention that "insufficient colon cleansing" was a exclusion factor, it is also known that patients with anatomic variations, like "fixation, tortuosity, laxity, and redundance" are also difficult cases to get a good colon cleansing. Did you evaluate the preparation of each patient, especially those that discontinued their preparation?

Answer: Yes, you are right. The poor bowel cleaning condition is an important index for our excluding the patients for colonoscopy. As the patients had huge amounts of turbid fecal water and fecal residues in their colon cavity, which could not be cleaned with the help of colonoscope flushing and suctioning, and the colon cavity was obstructed by dry stools or huge amounts of thin pasty stools, it was impossible for us to insert the colonoscope into the colon. Those patients were excluded from the study.

(6) Do the patients in question (those who were suspended their procedure) have any previous surgery? And for the women group, how many previous pregnancies or pelvic procedures have been done?

Answer: About 15-20% of the patients had previous abdominal or pelvic surgery, whose colonoscopy was suspended. As the surgery could lead to fixation and tortuosity, the operation history was considered an evaluation indicator in many articles. However, we consider it less accurate and less direct than fixation or tortuosity. So, we no longer used it as the research index. And other diseases, *e.g.*, tuberculosis and intraperitoneal metastatic cancer can also cause colon fixation and tortuosity.

4. References and typesetting were corrected.

Thank you again for considering our paper to be published in *World Journal of Gastroenterology*.

Sincerely yours,

Tao Gan

March 19, 2015