

ANSWERING REVIEWER'S

Reviewer 1.

Thank you very much for your comments.

Regarding language polishing, the manuscript was sent to “nature publishing” for language editing.

We decided to use the term unclassified rather than indeterminate because the term “indeterminate” is used in patients where colectomy was performed and pathologist were unable to make a definitive diagnosis. As our patients with unclassified IBD have not underwent colectomy we decided to use “unclassified” rather than “indeterminate” such as literature suggests.

“The Montreal Working Party has recommended that the term “indeterminate colitis” should be reserved only for those cases where colectomy has been performed and pathologists are unable to make a definitive diagnosis of either Crohn's disease or ulcerative colitis after full examination. In contrast, the term “inflammatory bowel disease, type unclassified” (IBDU) is suggested for patients in whom there is evidence on clinical and endoscopic grounds for chronic inflammatory bowel disease affecting the colon, without small bowel involvement, and no definitive histological or other evidence to favour either Crohn's disease or ulcerative colitis. In these patients, clearly infection would have been ruled out before the term IBDU might be applied”.

Satsangi J, Silverberg MS, Vermeire S, Colombel JF. The Montreal classification of inflammatory bowel disease: controversies, consensus, and implications. *Gut* 2006; **55**(6): 749-53. [PMID: 16698746 DOI: 10.1136/gut.2005.082909].

Reviewer 2.

Regarding language polishing, the manuscript was sent to “nature publishing” for language editing.

Patient inclusion was clarified, only patients included in the registry were included in the study. As you mentioned, some of the information from those patients diagnosed before the registry was created was obtained retrospectively and in fact was mention as a limitation as it clearly implies a selection bias. Clostridium difficile diagnosis was also clarified, as well as the scenery in which it was ordered (moderate-severe activity). It is true, the discussion is long, but we think that in such a complex disease every little detail counts. On the other hand it allows us to compare our national reality with that from other more developed countries, where biologic therapy is more available.

Reviewer 3.

We appreciate your comments. Undoubtedly our results are interesting and reflect our national reality where biologic therapy is not widely available.

To the Editor.

The reviewer's comments were addressed.

The manuscript was sent to language editing and we performed the *CrossCheck* powered by *iThenticate*. We uploaded two versions of it. The first one contains source matches > 1%, among them, the most important match is the following:

“Indeed, the European Crohn's and Colitis Organization Consensus recently stated that oral aminosalicylates are not recommended for the treatment of mild to moderate CD [38]. However, both the American and British National Gastroenterology Associations recommend the use of high-dose 5-aminosalicylic acid as the first-line treatment of mild ileal, ileocolonic or colonic CD [38].”

However, we do not think this corresponds to plagiarism as they are recommendations of different guides, and the reference from where it was obtained is clearly shown.

Further review of the matches concluded that the article had 0% CrossCheck. Both versions were uploaded in case you want to check this aspect.

We are very grateful for the opportunity to publish in your journal.

Thank you very much.

Dr. Rodrigo Quera

Gastroenterologist – IBD program

Clínica Las Condes