Review 1

The paper adds to the limited literature on endoscopic therapy of pT1b oesophageal cancer. The study is limited by its retrospective nature and 40% loss to follow up. Endoscopic therapy may be of value to patients unfit for esophagectomy but the indications are not stipulated in the paper. Endoscopic therapy for pT1b cancers is controversial, therefore a summary of the rationale for endoscopic therapy in these cases would add to its clinical value.

Response:

We readily agree that the study is limited due to its retrospective nature and 40% loss of follow up/patients opting out of further treatment. Endoscopic therapy for T1b cancers is controversial and therefore we would not recommend it as first line therapy, but only as a reasonable strategy in patients who refuse surgical intervention or those that would be poor surgical candidates (unfit for surgery) due to medical comorbidities, home support etc. We have added specifically to the discussion that unfit for surgery may include these factors, although clearly this would not be an exhaustive list.

Review 2

A retrospective study is reported to investigate outcomes and recurrences of T1b esophageal adenocarcinomas following endoscopic mucosal resection (EMR). The study population consist of 53 patients who underwent EMR in two tertiary centres between 2001 and 2013. Thirty-two of these patients had follow-up longer than 12 months and were included in the analyses. Recurrence developed in 28% of the patients, with the highest percentage (38%) in a subgroup treated with endoscopic procedures alone after the EMR. No predictors of recurrence were identified in the study. The authors should be acknowledged for their effort in collecting such data on a very specific group of patients that we know little about. I have some comments that will explore the data further; 1) In the follow-up section under methods I suggest that the authors provide some more information about the follow-up period. When/why did the follow-up stop? At a specific point in time? Because the patients died? Etc. 2) In "results"; How many patients died during follow-up? I suggest the authors address this by estimating 3- or 5- year mortality among the 32 patients included, and compare to the German results presented in the paper. 3) As an elaboration of 2; In addition to the percentages of recurrence reported, I think the authors should also report an overall (group A-C) 3- or 5-year cumulative risk of recurrence, using death as a competing risk. 4) When testing if a variable is a predictor for an outcome, univariate analysis only tests whether the variable is a predictor, but not a "specific/independent" predictor. To test that, multivariate analysis is required.

Response

The follow up was stopped either when the patient died or was lost to follow up within our system, referring physicians or primary care physician. There was no predetermined point in time for the end of follow up. The methods section has been updates to reflect this. Overall, 10 patients in our study died during follow up, of which 7 had died by 3 years giving an overall 3 year mortality rate of 22% which we

also have broken down by treatment group. We agree that using univariate analysis can only test if a variable is a predictor and not an independent predictor. Multivariate analysis was not undertaken as no variables were significant on univariate analysis.

Review 3

How did you decide to allocate the patients to different treatment group ? 2- How do you explain such a high recurrence rate in group C? 3- There is no data of tumor size in table 1 4- Your case number is low, you should increase it.

Response:

The decision to allocate the patient to these treatment groups was based on the treatment that was received in order to try to determine if there would be differences in outcomes based on various different treatment modalities that may be used in treating esophageal cancer. The recurrence rate in group C was 2/7 patients. Overall this is a very small number of patients and interpretation of this, as with all of our groups due to limited numbers is difficult. One recurrence was local near the surgical anastomosis and the other was metastatic involving the liver. It is possible that there could have been a field defect in the patient with local recurrence and micrometastasis that was unrecognized in the patient with metastatic disease. This has been addressed in the discussion section comparing our rate to other studies. In regards to tumor size, our data was limited in many of the patients that underwent EMR in that it was not reported in many of the endoscopic reports and thus was not included in our study. We acknowledge that our overall case number is low, however this condition is relatively rare and further attempts to include other centers for the study were made but proved to be very difficult.

Review 4

Firstly; I would like to congratulate all the authors for this study. All we know that esophageal cancer has poor prognosis and catastrophic results, and it is an insidious illness that can not be diagnosed early and easily. In this study, authors represents the results of early diagnosed esophageal cancer treated with different combinations. Please kindly find my suggestions below as a report; 1. Authors mentioned the aim of the study as "to evaluate the predictors of recurrence of T1b esophageal cancer following EMR."; however, if you want to find to evaluate predictor factors of recurrence, firstly you have to describe the dependent and independent parameters that you used, and you have to use univariate and multivariate analysis for this, as well. As a result of this, either use this statistics method or remove this sentence from the text. 2. Endoscopic theraphy has a high recurrence rate in the treatment of esophageal cancer. It seems that the surgical treatment is the main treatment modality in this disease. Please discuss your results with curative surgical resection results of the literature in discussion section. 3. Please check the references according to the journal's rule.

Response:

Univariate analysis was used to attempt to find predictors for recurrence and none were statistically significant. Therefore no multivariate analysis was done. Esophagectomy is the standard treatment for submucosal esophageal cancer, however risk of recurrence and metastasis remains despite esophagectomy, especially in those with higher risk lesions (i.e. deeper invasion, lymphatic/perineural involvement). Discussion has been updated to compare our results of surgical resection compared to other studies, however again due to our limited patient numbers, comparison is limited. References have been updated per the journal's rule.