ANSWERING REVIEWER COMMENTS

Reviewer 1

This looks to me as a narrative paper, with data being presented more like a book chapter, rather than a literature review. However, the subject can be of quite interest, especially considering the relative paucity of well-conducted studies upon the matter. Given the ongoing need to rely on small studies and historical data, such comprehensive and focused analysis should be welcome. Herein my comments/questions:

The authors report that stricturing CD (B2) is associated with younger age at diagnosis. In the subsequent paragraph they say that younger patients are more likely to present B3 CD manifestations.

Younger patients are likely to have increased risk of B2 and B3 CD (stenosing and fistulising) rather than B1 (non-stenosing, non-fistulising). This is the reason why younger patients are at higher risk of needing surgical intervention.

Please, avoid using the term "rectal stump" when evaluating subtotal colectomy.

Rectal stump is a common term used to describe retained rectum. However, we have changed rectal stump to retained rectum (for total colectomy) and retained rectum and rectosigmoid (for subtotal colectomy).

"Minimally Invasive Disease": probably "minimally invasive surgery" should be preferred.

Thank you for this suggestion. We agree with this suggestion and have amended.

While evaluating the potential of minimally invasive surgery, I would add the well known advantages of minimally invasive methods on postoperative peritoneal adhesions. In patients that are likely to receive further surgeries it represent a crucial factor. Please, argument this point.

It has been shown (and is logical) that minimally invasive methods in colorectal surgery have long term reduction in adhesional bowel obstruction when compared to open. However, most of the largest laparoscopic vs open studies in colorectal surgery report on short term outcomes not long term (including our paper published in Diseases of Colon and Rectum in 2012 (McKay et al)). I have included a citation from Rosin et al (which showed an adhesional obstruction rate of approximately 1% post laparoscopic surgery (with a median follow up of approximately 3 years)).

Reviewer 2

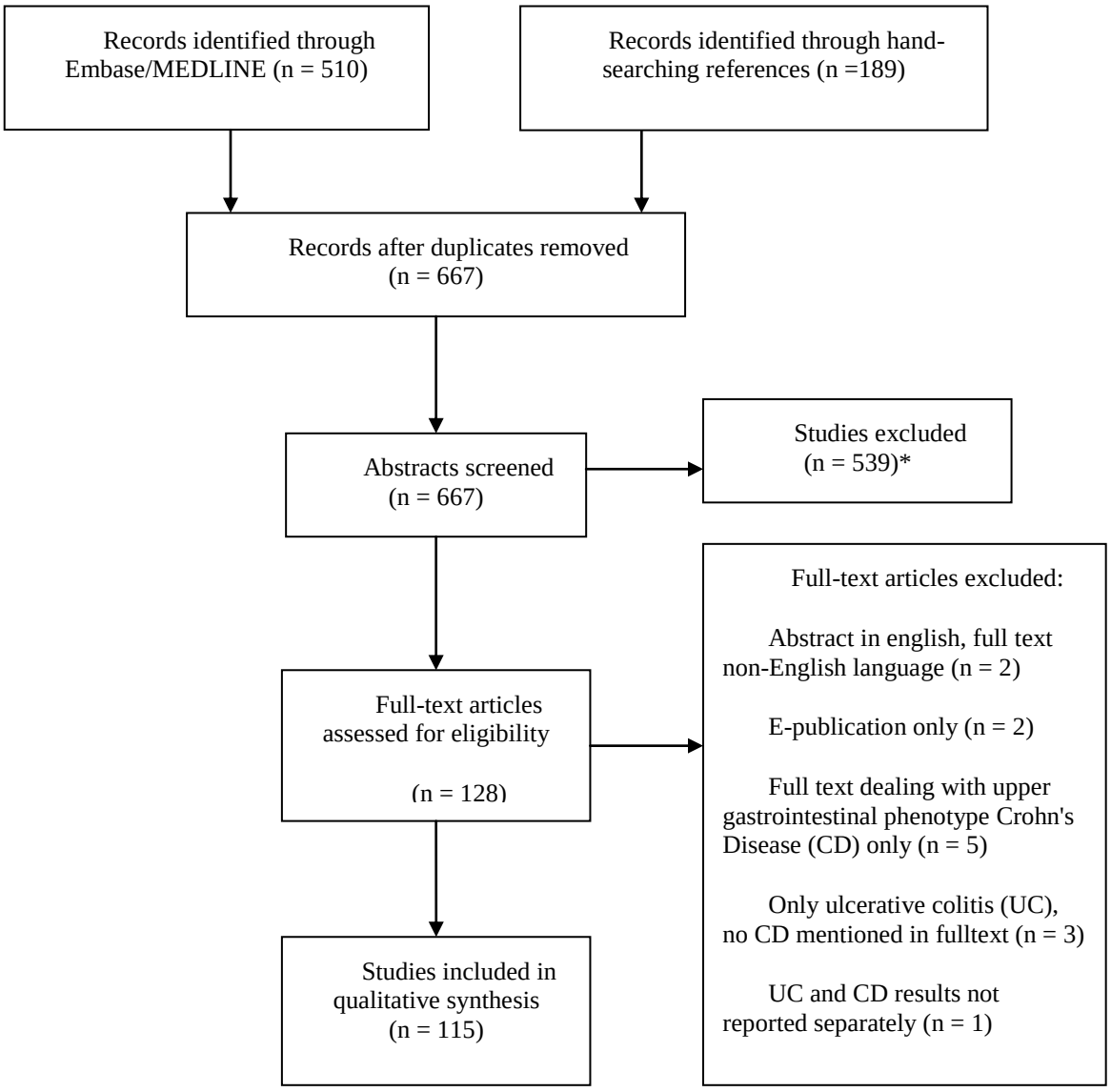
Thanks for your interesting article. The topic caught my attention and I was interested in reading this article immediately. The overall structure of the manuscript is concise, clear and comprehensive. I would suggest you to consult Format for Manuscript Submission-Review. According to this you should contain "Methods"immediately after "introduction", presenting the way that you conducted the literature search etc.

We initially included a PRISMA guidelines but we found that our topic was really broad and decided to submit it as a review article rather than a systematic review,

although our review was done systematically. This is the reason why we did not include our PRISMA guidelines. However, if you would like to include this, I have provided our PRISMA guidelines below.

The Preferred Reporting Item for Systematic Reviews and Meta-analyses (PRISMA) guidelines was used in this review. Two databases (MEDLINE and Embase from 2010-2016). Search terms included Crohn's disease, perianal, large bowel or large intestines or colon, small bowel or small intestines and surgery or surgical indications. 510 studies were identified through MEDLINE and Embase, 189 additional studies were found from hand-searching references.

Abstracts were reviewed by two investigators independently, and only studies excluded by both investigators were excluded. When only one investigator excluded the study, these studies were included for full text review. Studies excluded based on abstract included non-human studies, non-English language, studies on immunomodulators and biological agents only, no reference to surgery for Crohn's disease, reference to ulcerative colitis only, upper gastrointestinal Crohn's disease only or inflammatory bowel disease in general but not specifically Crohn's disease. Studies reporting mainly on immunomodulators but with references to surgery and studies on inflammatory bowel disease with reference to Crohn's disease were included for full text review. Only studies which reported in indications and surgical options for small bowel, large bowel or perianal Crohn's disease were eligible for qualitative synthesis. 128 full text studies were reviewed after duplicates were removed. 115 studies were included in this review (See PRISMA guidelines).



PRISMA flow diagram showing selection of articles for systematic review

* Studies excluded based on abstract included non-human studies, non-English language, no reference surgery in small bowel, large bowel and perianal disease CD, no abstract provided, studies primarily on immunomodulators, studies on UC only.

Comment (Q1)

I have signed conflict of interest statement and have attached a copy of this to my submission. I have mentioned the availability of this conflict of interest statement in the manuscript text.

Conflict of Interest Form

I, James W. T. Toh, have spoken to all co-authors, and we declare no conflicts of interest in the submission of our article, "**Indications and surgical options for small bowel, large bowel and perianal Crohn's Disease: review"** to World Journal of Gastroenterology.

Kind regards,

Dr James W. T. Toh

Comment (Q2)

I have summarised core tip to 100 words.

Most patients with Crohn's Disease (CD) will need surgery during their lifetime, with a third requiring multiple surgeries. It is important to optimise the medical and surgical management of CD in order to reduce rates of emergency surgery, surgical recurrence and intestinal failure. Surgical options depend on the phenotype of CD, with younger patients having more severe phenotypes. The most common indications for surgery include stricturing disease, fistulae and abscesses. Surgery for bleeding and cancer associated with CD is less common. This review critically evaluates the role and timing of surgery, and best surgical options in the management of CD. (100 words)

Comment (Q3)

Audio core tip provided for submission.

Comment (Q4)

All reference numbers have been reformatted to Endnote World J Gastroenterology style.

Comment (Q5)

Decomposable original figure 1 and PRISMA flow diagram have been provided – these can be easily changed by editor. Figure 2-5 are the original photos and they have been saved with the notations using the paint program. We do not have original photos without the notation, but these notations have been double checked and are accurate.

Comment (Q6)

The appropriate reference PMID and DOI has been provided where available. Referencing in ENDNOTE has been changed appropriately to World J Gastroenterology style.