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Dear Dr. Kong

Thank you very much for taking the time to consider this manuscript and for the constructive feedback of the editorial team. We have reviewed your comments and done our best to address them as described below:

They have also included the results of ongoing trial by the Florida Hospital group. However, in the chart I did not see it mentioned.

The cases from the Florida Hospital group were included in Table 1, but were incorrectly referenced to another Bang, et. al study. This has been corrected and the Bang 2016 entry in the table (row 9) that refers to the ongoing Florida Hospital group study is now correctly cited. Thank you for bringing this error to our attention.

If possible discuss separately use of LAMS in pancreatic pseudocysts and walled off necrosis as the latter also needs direct endoscopic necrosectomy.

This is an excellent point. In an ideal world, the complications of LAMS deployed for variable indications, such as for different pancreatic fluid collection types or in cases with or without direct endoscopic necrosectomy, would be considered separately. These indications and applications are all quite different and may well have significant variations in the incidence of different complications. Unfortunately, to date the literature has not carefully divided these cases or consistently specified the cases and subjects in whom complications have occurred. In that we are reviewing the literature, we are limited to describing that which has been published and therefore cannot effectively discuss differences in complications for LAMS used for pseudocysts and those used for walled off necrosis. However, given that we strongly agree with the reviewer in terms of the significant distinction between LAMS used for pseudocysts and those used for walled off necrosis, we have added a column to our table 1 specifying the PFC type for the subjects in each study. This allows readers to interpret complication rates in different studies in the context of the PFC types for which the LAMS were deployed.

Finally there is a large study from India (Lakhtakia et al.) which should also be discussed as they used an algorithm which was very helpful in increasing the clinical success and minimizing adverse events.

Thank you for bringing this study to our attention. We feel it is an excellent contribution to the discussion and, as such, have included its complication rates in our table 1 and a reference to its algorithmic approach in our discussion of stent occlusion (page 7 line 40-44).

Failure to deploy rates - What is the percentage of cases where the deployment of the stent failed

We have added a column to table 1 including rates of failure to deploy where available. Maldeployment or lack of technical success is described by most authors as a combination of failures of equipment and procedure. Authors have not characterized it as a complication in and of itself. Rather, they describe it as either leading to a complication or not. For example, if the device simply fails and the endoscopist elects to abort the procedure and place double pigtail stents, authors have not counted that as a complication. If, however, technical difficulty leads to perforation, as in the case from our own experience depicted in Figure 4, those cases have been included as complications. We agree with this approach and have chosen to treat maldeployment similarly in the body of our review, discussing it as a possible cause of complications rather than as a type of complication. That said, we agree that as a contributor to complication rates it provides valuable context to help readers interpret complication rates and thus should be included in Table 1 where available.

All cases of PFCs/WOPN are not amenable to endoscopic approach and as such would preclude LAMS in such cases.

This is quite true and clearly an oversight on our part. We have added several statements to our introduction (page 3, line 4-9, 14) specifying some of the limitations of an endoscopic approach and qualifying the strength of the endoscopic approach to PFC management as limited to those cases where it is technically applicable.

Thank you again for your constructive feedback. We appreciate your contributions to making our review as valuable a contribution to the literature as possible.

Sincerely,

Michael DeSimone, MD