Dear Professor Tarnawski,

Thank-you for considering our review entitled '**Current practices and future prospects for the management of gallbladder polyps: a topical review'** for publication in the World Journal of Gastroenterology. We appreciate the reviewer's comments and have made the necessary changes. Please see our response to these below.

Reviewer 00070545. No changes recommended

Reviewer 00505440. No changes recommended

Reviewer 03647271. Recommendations and changes as below

1. **Since most abdominal ultrasound examination was performed using HRUS in recent years, HRUS should not be described separately. Therefore, HRUS, 3D US, and contrast US should be included in TAUS section.** We have combined this section under the heading of TAUS as requested and discussed conventional US, HRUS, 3D-US and contrast enhanced US within it. The discussion on TAUS is focused within pages 7-9 and following this there is a more detailed discussion on the use of EUS

2**. EUS has several characteristic differences from TAUS, and it has been reported that the diagnostic accuracy for GBP is improved by adding contrast or doppler flow measurement in addition to conventional examinations. Therefore, it is necessary to describe the role of EUS in more detail compared to the advantages and disadvantages of the TAUS. I recommend quoting the following articles. – Eur Radiol. 2018 May;28(5):1994-2002. The efficacy of real-time colour Doppler flow imaging on endoscopic ultrasonography for differential diagnosis between neoplastic and non-neoplastic gallbladder polyps. – Gastrointest Endosc. 2013 Sep;78(3):484-93. Utility of contrast-enhanced harmonic EUS in the diagnosis of malignant gallbladder polyps (with videos). – Surg Endosc. 2013 Apr;27(4):1414-21. Differential diagnosis between gallbladder adenomas and cholesterol polyps on contrast-enhanced harmonic endoscopic ultrasonography.** These three papers have been added to our text within the EUS section as recommended. Please see paragraph 2 and 3 on page 10.

3. AJCC TNM stage for GB cancer was revised in 2017, and N stage was determined by involvement of number of LN. Therefore, you should revise the introduction section of AJCC stage. The language in this section has been changed to highlight that the N stage of the tumour is reflected in the number of lymph nodes which have disease present as per the 8th edition of AJCC staging. Please see the second paragraph of the introduction on page 5.

4. In the section of surveillance, you should the exact follow up schedule of ESGAR guideline. In this guideline, risk factor is important determinant for further treatment. In case of both 6-9mm size without risk factor and size <5mm with risk factor, FU US is recommended at 6 months, 1 year and then yearly up to 5 years. In terms of no risk factor < 5mm polyp, 1 year, 3 years, and 5 years US are advised. This has been amended to include the follow up the complete guidelines as presented in ESGAR. Please see page 14 paragraph 2 under the surveillance section for these changes.

5. In addition, ESGAR guideline suggested the prophylactic cholecystectomy for 6-9mm sessile polyp. You should clarify this indication in your paragraph of sessile morphology. We had previously mentioned that ESGAR recommended cholecystectomy in sessile polyps of less than 10mm. We have amended this to recommend cholecystectomy for sessile polyps between 6-9mm. Please see the sessile morphology section on the first paragraph on page 16.

6. Because congenital anomaly of biliary system such as APBDU and choledochal cyst has a high risk for gallbladder cancer, I think you'd better describe this risk factor in your paper. No studies have looked for an association between congenital anomalies and gallbladder polyps however we recognise that both of these conditions are associated with gallbladder cancer. The management of choledochal cysts involves surgical removal with simultaneous cholecystectomy and in APDU, cholecystectomy is recommended prophylactically due to the risk of gallbladder cancer. We do not therefore feel that either of these congenital anomalies have a role to play in the follow up or influence the management of gallbladder polyps as surgical intervention is required irrespective if polyps are present or not.

Reviewer 03471208. Recommendations and changes as below

1. Extensive language polishing is required. In addition spelling, grammar, typing errors should be checked and corrected extensively. English is the first language of all the authors of this review and we feel this is reflected in the writing of the text. We have read through the text and polished the language where we felt appropriate.

2. Some places references are missing, kindly update with recent updated references. References have been added where and when it was felt to be necessary. In particular, the role of EUS has been updated with the most recent evidence. Please see pages 9 and 10. Older references have been included in certain places for historical purposes while over 30 of the references included have been from papers published within the last ten years and represents the most recent up to date evidence.

3. The authors are advised to add one more section added as: Genetic risk factors associated with the disease. There has been no studies looking at genetic risk factors in gallbladder polyps, however, we accept that there are genetic risk factors associated with gallbladder cancer and therefore it is appropriate to highlight this in this review as future studies should also consider the role of genetic risk factors in gallbladder polyps. Please see the second main paragraph on page 18

Reviewer 03213658.

It is recommended to delete some old documents and supplement the literature in recent 5 years.

See section above under reviewer 03471208.

We look forward to your response following the necessary changes.

Many thanks

Stephen McCain