

**Reviewer's code: 03699990**

**Comment:**

This retrospective study was to evaluate the optimum management strategy for patients with RMCO by comparing the perioperative and oncologic outcomes of bridges to surgery using decompression tubes and metallic stents. Similar researches include “Rintaro Moroi ,et al.Gastroenterology Research and Practice Volume 2014, Article ID 372918, 6 pages<http://dx.doi.org/10.1155/2014/372918>”and” Akihisa Matsuda,et al. journal of surgical research \_ o c t o b e r 2 0 1 6 ( 2 0 5 ) 4 7 4 e4 8 1” etc,which focus on Comparison of Short-term outcomes. This retrospective study includes Comparison of Short-term outcomes and the long-term outcomes between decompression tubes with metallic stents for the management of RMCO . As the retrospective design, The main limitation is the small sample size. But this study is a summary of clinical experience, there is still a certain reference value for patients with RMCO in bridge to surgery. Whether the included patients in this study are 18 in TDT group and 17 in SEMS group because 3 and 2 patients suffered technical or clinical failure of tube insertion should be excluded respectively.

**Response to comment:**

We thank the reviewer for this valuable comment. According to the reviewer's suggestion, we compared the long-term outcome of decompression tubes and SEMS according to the treatments actually performed. Although there was no significant difference between the actually performed treatments, the 5-year survival rates and 3-year DFS rates were better in the decompression tubes group as with the intention to treat analysis.

We have added additional paragraph to results as following.

**On Page 14 of the RESULTS we have added a paragraph as following:**

***Effects of the treatments actually performed on OS***

Five patients who were scheduled for treatment with a decompression tube or SEMS received emergency surgery due to technical or clinical failure. The 5-year survival rates of patients actually treated with the decompression tube and SEMS were 84.4% and 38.8%, respectively (P = 0.110, log-rank test), and the 3-year DFS rates were 71.3% and 51.8%, respectively (P = 0.113, log-rank test).

**Reviewer's code: 00039578**

**Comment:**

The authors prove in this series that preoperative bowel decompression using trans-nasal and trans-anal decompression tubes for right-sided malignant colonic obstruction is safe and may improve the long-term outcomes. They also state that this approach is superior to self-expandable metallic stents in overall survival and disease free survival. This is a small series, divided in three groups, retrospective and non-randomized. Its main interest is to show the authors approach in patients with right-sided malignant colonic obstruction using long tubes (trans-nasal and/or trans-anal) which is not usual outside Japan. This method should be assessed in other centers, possibly in a multi-center randomized prospective study, in order to confirm the results and to make a recommendation for all centers treating this patients.

**Response to comment:**

We thank the reviewer for this valuable suggestion. We agreed that this study requires external validation and a randomized prospective study is appropriate. We regard present study as initiating research of preoperative decompression for RMCO and we have rewritten a part of DISCUSSION.

**On 1st line of Page 19 of the DISCUSSION we have rewritten as following:**

their efficacy for the management of RMCO should be evaluated in a multi-center randomized controlled study.

**Reviewer's code: 02855587**

**Comments 1:**

Nicely written manuscript. Interesting to read and instructive. I have no substantial criticism but minor comments: Right side colon obstruction don't carry high mortality nor morbidity. Morbidity and something-less mortality are higher then elective surgery. Update biblio.

**Response to comment 1:**

We thank the reviewer for these valuable comments. First, we agree that the emergency surgery for right-sided malignant colonic obstruction don't carry so high mortality nor morbidity. According to the reviewer's comment, we have rewritten a part of INTRODUCTION as following.

**On Page 6 of the INTRODUCTION we have rewritten as following:**

Although patients with malignant colonic obstruction typically undergo emergency surgery, the procedure is associated with higher rates of mortality and morbidity compared to elective surgery[6].

**Comments 2:**

I understand this is your standard treatment for large bowel obstruction. Please make this crystal clear. If this is the case, explain this is the reason you are not capable to tell whether this routine decompression phase of the treatment is the reason for high percentage of laparoscopic surgery.

**Response to comment 2:**

We thank the reviewer for this valuable comment. According to the reviewer's suggestion, we have rewritten the sentence in Study design as following. As we routinely used a decompression tube preoperatively in all patients with RMCO from 2007 to 2011 and preferentially used SEMS since 2012, in the present study, we thought the reason for the higher rate of laparoscopic surgery in patients in the SEMS group might be historical. We have added a following sentence about it in the DISCUSSION part.

**On Page 8 of the MATERIALS AND METHODS we have rewritten as following:**

We routinely used a decompression tube preoperatively in all patients from 2007 to 2011. Following the initiation of coverage by national health insurance in 2012, SEMS have been the standard method for preoperative bowel decompression.

**On the 1st line of page 18 of the DISCUSSION we have rewritten:**

In the present study, the reason for the higher rate of laparoscopic surgery in patients in the SEMS group might be historical, as we routinely used a decompression tube preoperatively in all patients with RMCO from 2007 to 2011, and have preferentially used SEMS since 2012.

**Comments 3:**

In the discussion, disclaimer on the reason for choosing one over the other decompression practice. Is this due to availability of experienced endoscopist or radiologist?

**Response to comment 3:**

We thank the reviewer for this valuable comment. In this study, there was some historical factor in selection of decompression tube or SEMS as we mentioned above. In addition, as the reviewer mentioned, the reason may be due to the preference of surgeon's preference and availability of endoscopist. However, because of the limitation of retrospective study, detailed individual reason for selection of the procedure was uncertain. To reduce the possibility of such selection bias, we applied propensity scores.

**Reviewer's code: 00068215**

**Comments:**

I recommend to also discuss the quality of life measures between the two procedures ( decompression tube vs self-expandable metallic stent) before surgery, the only way to measure the patient centered outcomes. Taking into account the quality of life assessment in parallel with statistical methods of data analyzed, we can develop a basis for individualized clinical decision making.

**Response to comment:**

We thank the reviewer for this valuable suggestion. It is important to assess the quality of life during the bowel decompression. As this is a retrospective study, to analyze the quality of life measures is difficult. In addition, to the best of our knowledge, there were few study about quality of life of patients with decompression tubes probably because the worse quality of life measure is obvious. We therefore have mentioned about it in the DISCUSSION as following.

**On Page 18 of the DISCUSSION we have added a sentence as following:**

In addition, the preoperative quality of life of RMCO patients who are treated with a decompression tube is obviously worse than that of those treated with SEMS. The fecal odor from the tube and the presence of the tube itself make patients feel extremely uncomfortable[16]. Nevertheless,