Dear Reviewers,

Thank you for your helpful reviews. Below you will find our responses to each point brought up. Please let us know if there is anything else that can be improved.

Sincerely,
M. Phillip Fejleh, MD

Reviewer 1:
This paper does not organize the topic well.

Thank you for reviewing our paper. Our goal was to organize the manuscript in a logical manner.

Reviewer 2:
This manuscript is well written editorial and this reviewer require additional short comment concerning two points if it is possible.

1, If it is possible please give a short comment in the manuscript concerning a treatment below. High-dose barium impaction therapy for the recurrence of colonic diverticular bleeding: a randomized controlled trial. Nagata N, Niikura R, Shimbo T, Ishizuka N, Yamano K, Mizuguchi K, Akiyama J, Yanase M, Mizokami M, Uemura N. Ann Surg. 2015; 261(2):269-75

This is an excellent point. Our manuscript emphasized endoscopic treatment modalities for diverticular disease, which is why we had to leave out relevant therapies like the one mentioned here.

2, If it is possible please give a short comment on an opinion below. Endoscopic hemostasis is only indicated for diverticulum with stigmata of recent hemorrhage (SRH), but the detection rates of SRH are relatively low. Therefore, efforts to increase the detection are the other key for improving CDB management. Urgent colonoscopy and the triage by early contrast enhanced CT may be candidates for the efforts and further data are necessary to conclude. Epidemiology of colonic diverticula and recent advances in the management of colonic diverticular bleeding. Kaise M, Nagata N, Ishii N, Ohmori J, Goto O, Iwakiri K. Dig Endosc. 2019 Oct 3. doi: 10.1111/den.13547. [Epub ahead of print]

Another great point. Since our goal was to highlight only endoscopic management of diverticular bleeding, we did not discuss triaging patients using contrast-enhanced CT. We believe that all patients presenting with hematochezia should undergo prompt bowel preparation and colonoscopy if they are clinically stable. Thank you very much for your thoughtful questions and for providing useful references.

Reviewer 3:
The authors had reported the recent progress on the colonic diverticular disease management, especially on the treatment of diverticular bleeding and stenting for strictures related to prior acute diverticulitis.

1.The authors reported that "a recent meta-analysis comparing coagulation, EBL, and TTS clips in the treatment of diverticular bleeding demonstrated comparable rates of initial hemostasis and prevention of early rebleeding between the three treatment modalities", and also stated that "localization of such lesions can be difficult given the potential for numerous diverticula throughout the colon that require investigation, inadequate bowel preparation, and the fact that diverticular bleeding frequently stops spontaneously or can be intermittent". Is there any data comparing the outcome among conservative treatment and these

progress management on colonic diverticular bleeding? Further large-scale prospective randomized studies might be needed with regard to utility and optimal application/patient selection.

This is an excellent question, thank you. We agree that RCTs could clear up any confusion about patient selection, etc. I did come across the paper (below) that used a survey to examine rebleeding after conservative management versus endoscopic treatment of patients with diverticular bleeding. However, given the fact that it was a survey, your point about needing an RCT to answer the question remains.

Digestion. 2016;94(4):186-191. doi: 10.1159/000452301. Epub 2016 Dec 9.

Long-Term Clinical Course after Conservative and Endoscopic Treatment of Colonic Diverticular Bleeding.

Mizuki A[1], Tatemichi M, Nakazawa A, Tsukada N, Nagata H, Kanai T.

2.The authors reported that "Our experience with colonic stenting of diverticulitis-associated strictures has been largely very favorable; in >75% of patients, it has permitted colonic decompression and prepping followed by 1-stage segmental resection in lieu of emergency colostomy followed by stoma takedown and colo-colonic anastomosis". However, these strictures tend to be relatively rigid, is there any complications following the SEMS procedure should be informed for those un-experienced beginners?

The main complication per se about which to be informed is that the stent either does not sufficiently expand and that it can migrate (distally or proximately). The former is due to the relatively rigid, fibrotic nature of these strictures, as commented upon by the reviewer, while the latter is due to the fact that there is no neoplasm in the lumen onto which the stent can readily grip. We therefore routinely use through the scope clips to secure the distal end of the stent to the mucosa and thereby mitigate the risk of migration in either direction.