Dear

Prof. Dr. Joo Young Cho
Prof. Dr. Bing Hu
Prof. Dr. Anastasios Koulaouzidis
Prof, Dr. Sang Chul Lee
Editors-in-chief of the World Journal of Gastrointestinal Endoscopy

We are resubmitting the article entitled (name changed, as recommended) "**Feasibility of endoscopic papillary large balloon dilation to remove difficult stones in patients with nondilated distal bile ducts"** for publication in the World Journal of Gastrointestinal Endoscopy after the alterations suggested by the reviewers and professional English language revision with certificate (file attached).

**Reviewer 1:**

The review was written in Korean, and we used Google translator to understand it

1) *"Specific Comments to Authors: I deeply concerned about the safety of EPLBD in the nondilated CBD patients, because there were two perforation cases only in that group. So, this article should change the conclusion and the title include the special caution about the safety. EPLBD of 12-15 mm or larger was performed on a patient whose distal CBD was not stretched, and there were only 2 cases of perforation. There was no difference in other contingencies such as PEP. So, I think it's dangerous to conclude that it's safe. It was said that it can reduce the time compared to lithotripsy using SpyGlass, but I think it is right to remove the gallstones using mechanical lithotripsy after EST + EPBD rather than EPLBD and use temporary biliary stenting. In conclusion, it requires sufficient additional description for the content, and a major revision is needed to change the title accordingly."*

The title and the conclusions were changed as requested to "**Feasibility of endoscopic papillary large balloon dilation to remove difficult stones in patients with nondilated distal bile ducts"** instead of "is safe". Conclusions were changed in a similar manner as suggested.

**Reviewer 2**

1) *"The drawback is inherent in design. There was a selection bias …"*

The above mentioned drawback is thoroughly discussed in the second to last paragraph

2) *"The authors have used terms such as non-dilated distal bile duct, narrow bile duct, thin bile duct at different places. There should be uniformity in terminology with clear definitions."*

The terms were defined in the methods section and unified in the same terminology in all the text, as suggested.

3) *"Were all patients dilated up to 15 mm or some with tight narrowing and smaller duct managed by 12mm or 13.5mm dilatation?"*

No. A few patients were dilated to 4 ATM (12 mm) if with this pressure waist disappearance was observed. If a significant waist persisted with 4 ATM, the balloon was inflated to reach a higher pressure (according to the manufacturer, 3.5/4 ATM corresponds to 12 mm and 8 ATM to 15 mm). Nonetheless, even with that pressure in the balloon system, it is obvious that some nondilated distal ducts did not reach 15 mm since waist disappearance were not complete in all cases. This was better explained in this new version of the manuscript (third paragraph of the Discussion section).

4) *"As shown in Table 1, need for mechanical lithotripsy in non-dilated duct was 25% as compared to 6.4% in those with dilated duct. This was inspite of significantly smaller and lesser number of stones in group with non-dilated duct. This is important observation and does point towards difficult endotherapy results in this group. This needs to be highlighted in result section & in discussion. What is author's explanation for this?"*

This was discussed and explained in the third paragraph of the new manuscript's version.

5) *"How was procedure time defined. Author should mention the range of procedure time in 2 groups."*

The following sentence was added to the "Procedure method's" part of the Material and Methods section: "Procedure time was measured in minutes from the insertion of the duodenoscope into the patient's oral cavity to its retrieval."

6) *"Severity of complications is better by Atlanta criteria rather than Consensus criteria used by author."*

The authors do not agree with the reviewer. The Atlanta Consensus criterium is for acute pancreatitis severity. The study deals with ERCP complications as a whole (not only post ERCP pancreatitis, but also perforations, bleeding and so on). This way, the ESGE consensus (Dumonceau et al. Endoscopy2020;52:127-149; reference 9) used by the authors was more appropriate. Indeed, this European consensus is based on the American workshop published by Cotton PB, Eisen GM, Aabakken L, et al. ("A lexicon for endoscopic adverse events: report of an ASGE workshop." Gastrointest Endosc 2010; 71:446–454.)

Thank you in advance.

Yours sincerely,

Dr. Julio Pereira Lima, MD MSc PhD

Corresponding Author
Department of Gastroenterology and Endoscopy
Hospital Santa Casa de Misericórdia de Porto Alegre
jpereiralima@terra.com.br