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CLASSIFICATION	LANGUAGE EVALUATION	RECOMMENDATION	CONCLUSION
[ ] Grade A (Excellent)	[ ] Grade A: Priority Publishing	Google Search:	[ ] Accept
[ ] Grade B (Very good)	[Y] Grade B: minor language polishing	[ ] Existed	[ ] High priority for publication
[Y] Grade C (Good)	[ ] Grade C: a great deal of language polishing	[ ] No records	[ ]Rejection
[ ] Grade D (Fair)	[ ] Grade D: rejected	BPG Search:	[Y] Minor revision
[ ] Grade E (Poor)		[ ] Existed	[ ] Major revision
		[ ] No records	

COMMENTS TO AUTHORS

Tal and Vermehren made a comprehensive and overall review of colon capsule endoscopy (CCE) in its current status and future directions. With the introduction of the 2nd generation CCE, the diagnostic accuracy of CCE for the polyp detection has been significantly improved and the preliminary data suggest it may be useful to monitor patients with inflammatory bowel disease by this minimally invasive wireless technique. Due to the limitations of the inability to take biopsies and the procedural costs, current indications of CCE aim at patients in whom conventional colonoscopy cannot be or has been incompletely performed. In addition, given the poor acceptance of its usefulness as a screening tool with regard to CRC prevention, CCE should be tested in large-scale screening programs. Though this paper is relatively interesting and informative; however, there are a lot of criticisms and have the following comments that the authors need to address before the manuscript is suitable for publication. Major Compulsory Revisions: 1. Due to the major drawbacks of CCE, the inability to take biopsies and the procedural costs, it seems that CCE could not take more advantages than MRI (or CT)-applied virtual colonoscopy, as the latter procedure would be cheaper and the possibility of high quality images. 2. In the Introduction section, FDA approval has been granted for CCE basing on data from a 16-site clinical trial involving 884 patients that assessed the safety and effectiveness of CCE in detecting adenomas at least six millimeters in size. Therefore, how about polyps at the size of 5 mm, of which would be missed by CCE? Five-mm adenomatous polyps should be removed if detected. 3. In the Colon capsule endoscopy – technical features and safety paragraph, an additional energy saving feature has been introduced to CCE-2 which captures only 14 frames per minute until small bowel images are detected. Please check again only 14 or 4 frames per minute? Why do company engineers (Given Imaging Ltd, Yoqneam, Israel)

design energy saving feature that has been introduced to CCE-2 which captures only 14 frames per minute until small bowel images are detected but not when colon are detected? It would attain a more energy saving goal. 4. Title of table 2 showed the complication rates reported from studies involving both first and second generation colon capsules; however, most complications from colonoscopy-related not by CCE? 5. Suggest authors to add the accuracy rate of individual study into table 4. 6. The potential capsule retention would be another obstacle for patients suspected with malignancy; however, colorectal cancer is the major disease that we must treat in our patients. The actual role of CCE would be significantly affected in clinical practice. Furthermore, with the introduction of colonoscopy by IV anesthesia, the case numbers in whom conventional colonoscopy cannot be or has been incompletely performed would be significantly decreased. 7. In Summary paragraph, its acceptance among patients and accuracy for the detection of pathologic findings has been studied for a variety of indications including the detection of polyps and adenomatous lesions as well as for monitoring inflammatory bowel disease. For ulcerative colitis, CCE would be fine whereas for Crohn's disease complicated with lumen stenosis, CCE would probably lead to the capsule retention as patients with malignancies.