Response letter

1. The reviewer does not understand description of the ES "wound" in patients who did not rebleed (Table 3). By definition, these patients had to have active bleeding to undergo treatment. What does it mean to have a non-bleeding pigmented spot or a non-bleeding adherent clot or even a non-bleeding visible vessel (something decidedly unusual in the reviewer's experience)?

Reply:

1. After discussion of all authors, the term " **pigmented spots** " will be changed to " **red spots** " to avoid confusion and describe bleeding stigma of ES wound clearly

2. All the enrolled patients had overt gastrointestinal (GI) bleeding that manifested as passage of tarry stool and/or vomiting with blood. The endoscopic therapy was performed within 24 hours after the occurrence of overt GI bleeding. On endoscopic examination for delayed post-ES bleeding, we considered that the episode of overt GI bleeding was due to post-ES when there was no obvious bleeder in the upper GI tract, and when there was stigmata of recent hemorrhage (SRH) of the post-ES papilla. These stigmata we used were basically based on the Forrest classification for peptic ulcer bleeding. However, because this was a retrospective study, we could only classify the endoscopic features of post-ES bleeding into four categories: active bleeding (figure 1), non-bleeding visible protruding vessel (figure 2), non- bleeding adherent blood clot (figure 3), and non- bleeding red spots (figure 4).

3. Although the methods of endoscopic hemostasis for post-ES bleeding mirror those for peptic ulcer bleeding, there has been no guideline or

consensus for the management of post-ES bleeding. Since all patients with overt GI bleeding, we treated all patients with SRH in order to minimize the risk of re-bleeding. We might have overtreated the subgroup of patients that had stigmata of red spots since this subgroup of patients did not have any re-bleeding event. We mentioned it in the "Discussion section" stated that ES wound with non-bleeding red spots may be of low risk of re-bleeding even without prophylactic treatment. Our result supported the proposed algorithm for treatment of delayed post-ES bleeding that stigmata of red spots did not need endoscopic therapy [reference 1].

[Reference 1]:

Ferreira LE, Baron TH. Post-sphincterotomy bleeding: who, what, when, and how. Am J Gastroenterol 2007;102(12):2850–2858

Figure 1, active bleeding

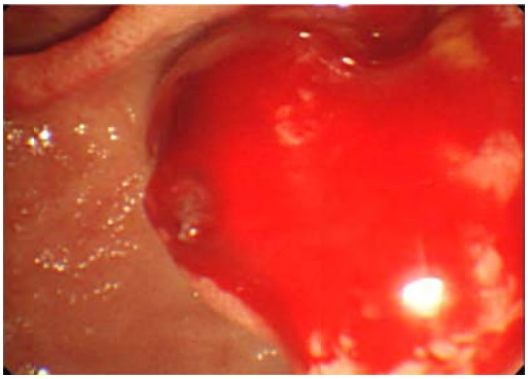


Figure 2, Non-bleeding visible vessel

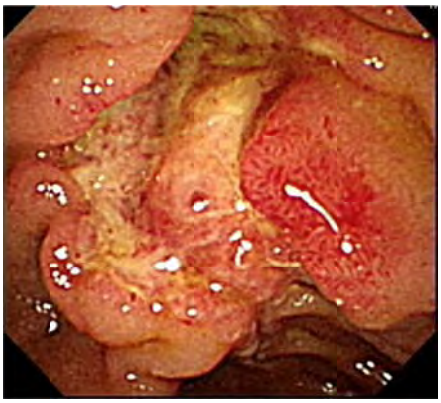


Figure 3, Non-bleeding adherent clot

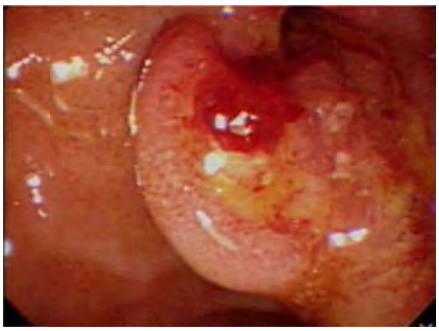
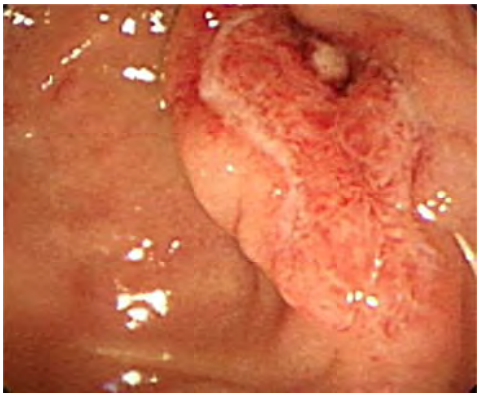


Figure 4, Non-bleeding red spots



2. You make the claim that monopolar grasping forceps by Olympus are as effective as the other modalities used to treat post-ES bleeding, yet you offer no data to support this claim. Either supply such data, remove the claim, or

state that this is based on the authors' unpublished experience.

Reply:

This was based on our unpublished experience. Learning from the skills of endoscopic submucosal dissection, we found that a monopolar grasping forceps was also effective to control post-ES bleeding. We add "unpublished experience" in the manuscript (Line 5, paragraph 2, page 11)

3. Minor grammar suggestions:

a. Introduction, line 10 = The majority of immediate post-ES bleeding is self limited…

b. Page 9, paragraph 4, line 4 = required multiple sessions more often than those…

c. Page 10, paragraph 2, line 9 = were not statistically significant after multivariate analysis.

d. Page 11, paragraph 1, line 2 = yet not statistically significant by multivariate analysis.

e. Page 11, paragraph 2, line 4 = have been reported…

f. Page 12, line 2 = immediate post-ES bleeding.

Reply:

We have revised the sentences based on the reviewer's suggestion