The article seeks to cover a complex and controversial area and in general outlines most of the relevant areas, and in particular, screening and surveillance. Areas of future development including biomarkers are nicely summarised. Feedback: my opinion is that the article needs restructuring including outlining controversial areas more clearly.

In response to a review where feedback was about outlining controversial areas more clearly; we have added sentences to highlight the most controversial areas. These include stating that we have established the overall risk but that we are not able to arrive at individualised risk as we are limited with surveillance intervals which are based on crude markers of perceived risk. We have also added that new evidence for earlier ablation of dysplasia has changed the goals of surveillance; that the best risk modification to reduce the risk of dysplasia/cancer is not widely practiced; and that sampling error and pathological interpretation are subject to significant errors but adjuncts to these methods are not widely taken up.

The article cites reference articles in areas, where it is important to cite the original evidence. Some of the citations are incorrect (e.g. Pohl Endoscopy 2007 relates to computed virtual chromoendoscopy, not OCT).

We have corrected all citations flagged as incorrect and reviewed all the other references for errors.

Issues with existing ablative therapies should be discussed, and newer ablative therapies mentioned, e.g. cryotherapy.

We have discussed the issues surrounding current ablative therapies and have added information about cryotherapy, a more novel approach in ablation.

Some areas of controversy are not outlined clearly or adequately enough. For example, origin of Barrett's columnar cell, or methods of endoscopically visualising or picking up dysplasia.

We believe that this is a full paper which covers a wide range of the controversies around Barrett's oesophagus with a clinical focus so we are happy to write a separate article on the suggestion of the origin of Barrett's columnar cells (pathogenesis). We have also covered the main methods of endoscopic visualisation

and dysplasia detection which take place in UK practice but we are happy to cover any further specific areas in a separate article.

I would also recommend the author(s) are more concise with their language in certain areas, which would keep the reader more engaged and allow inclusion of important new technological advances, whilst discussing their failings in adequate depth (e.g. endomicroscopy - takes too much time although as mentioned can be accurate).

We have not only shorted the endomicroscopy section but been more concise throughout the entire article

The excellent review by Amadi C and Gatenby P is read with interest. The review summarizes the main controversial issues regarding Barrett's esophagus (BE). The manuscript is suitable for publication after minor revision. Specific comments ?Definition of BE is one of areas of debate. This issue should be discussed in more detail.

Regarding the definition of Barrett's oesophagus, the key question is whether intestinal metaplasia is required and the minimum length of Barrett's oesophagus needed to justify surveillance. We have discussed both in detail and included comparisons between the main national guidelines.

?The Authors should spend time to explain the differences in the prevalence of BE in USA in comparison with Europe. ?The cost-effectiveness of screening and surveillance should be discussed in more detail. ?

We have explained the difference in the prevalence of Barrett's oesophagus in the USA versus Europe and have referenced appropriately [reference 22]. We have also discussed the cost-effectiveness of endoscopic screening and surveillance in more detail citing another study where the possibility of streamlining was researched successfully [reference 41].

?A separate Table should be added regarding the main results of chemoprevention.

We have tabulated the main results of the studies investigating chemoprevention in Barrett's oesophagus

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?The Authors should discuss why the systematic biopsy protocol does not work in the real world. ?The availability, reality in the every-day practice and cost-effectiveness of adjuncts to standard systematic biopsy (chromo endoscopy, NBI, EUS, computed virtual chromo-endoscopy, auto fluorescence) should be discussed.

We have addressed the reasons why systematic biopsy protocols do not work in the real world (time and resource implications, no widely used system for targeted biopsies) and the reality of the use of adjuncts in the community (only in specialist centres for research with a lack of recommendations).

This is a meaningful paper about Barrett's oesophagus. However, in order to be acceptable for publication, some modifications are required. The major points: 1. Many researchers consider that the term "Barrett's esophagus" should be replaced by "columnar-lined esophagus", it is still a current controversy. Especially, different country has different diagnose standard. We suggest the author could talk about this part.

This is now much clearer with a clear definition given but its debateable status mentioned; alongside the factors which are considered in surveillance.

And now, some evidences show the Barrett adenocarcinoma prevalence different between west countries and east countries. What is the possible reason for it ?

We have included a meta-analysis on the cancer risk of Barrett's oesophagus which shows that there is no difference in incidence between countries across the world but further risk stratification is still required [reference 23].

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2. The title of paper is Barrett's oesophagus: Current controversies ,but the pathogenesis of Barrett's oesophagus is still remains unclear, there are a lot of controversy, it should be discussed.

We believe that this is a full paper which covers a wide range of the controversies around Barrett's oesophagus with a clinical focus so we are happy to write a separate article on the suggestion of the origin of Barrett's columnar cells (pathogenesis). We have also covered the main methods of endoscopic visualisation and dysplasia detection which take place in UK practice but we are happy to cover any further specific areas in a separate article.

And there are minor points to the author: 1. What is the meaning of "art evidence" in the paragraph of "This editorial seeks to highlight the current state of the art evidence and landmark studies published since the formulation of the various guidelines to update clinicians and direct future management/research into Barrett's oesophagus"?

We have rephrased the sentence "current state of the art evidence" to "current evidence".

The phrase of Oesophageal cancer on Key words should be replaced by Oesophageal adenocarcinoma, because only the oesophageal adenocarcinoma is usually associated with Barrett's oesophagus, not the oesophageal squamous carcinoma, but oesophageal cancer include the both of them.

We have changed the key word to oesophageal adenocarcinoma.

In the paragraph of" What is the prevalence of Barrett's oesophagus ?", the prevalence of Barrett's oesophagus in the unselected general population is between 1-2% in European studies (Italian 1.3%, n = 1033 and Swedish 1.6%, n = 1000), the eighth reference can not be found, and the format is a mess. The original reference about it are as follows, maybe you can use it to replace. Ronkainen J, Aro P, Storskrub T, et al. Prevalence of Barrett's esophagus in the general population: an endoscopic study.[J]. Gastroenterology, 2005, 129(6):1825-1831.(Swedish 1.6%) Zagari R M, Fuccio L ,, M-A W, et al. Gastro-oesophageal reflux symptoms, oesophagitis and Barrett's oesophagus in the general population: the Loiano-Monghidoro study.[J]. Gut, 2008, 57(10):1354-9. (Italian 1.3%)

We have corrected this and all citations flagged as incorrect and reviewed all the other references for errors.