

Reviewer #1:

1. The review does not mention the application in malignant or benign lesion

Response: Thank you for the suggestion. I have added the following information (highlighted in yellow) on this point in the first paragraph of the “CONNECT-E trial” section: Patients endoscopically diagnosed with esophageal squamous cell carcinoma or basal cell carcinoma with a tumor diameter ≥ 20 mm and clinically diagnosed with intramucosal cancer (cT1a) or slightly invasive submucosal cancer (cT1b-SM1) were randomly assigned to the conventional ESD (n = 116) and CWL-ESD (n = 116) groups.

2. The lesion size / extent is not clearly defined where these techniques can be applied

Response: Thank you for your comment. The choice of CWL-ESD or ESTD for performing esophageal ESD has not been standardized yet. I believe both techniques are helpful in esophageal ESD. Moreover, combined CWL-ESD and ESTD can be feasible and facilitate esophageal ESD procedures, especially for lesions covering the whole circumference of the esophageal lumen. I have described this point in the last paragraph of the section “Endoscopic submucosal tunnel dissection—a promising option for managing challenging esophageal lesions” in the original manuscript as follows: A recent study showed the efficacy of the combined use of traction devices and the pocket creation method in colorectal ESD[7]. The pocket creation method has the same principle as ESTD. Therefore, CWL-ESD can be combined with ESTD, which might facilitate esophageal ESD.

3. The utility in robotic / laparoscopic methods is not addressed

Response: This article aimed to highlight the use of CWL-ESD and ESTD in the esophageal ESD based on recent studies. I understand the importance of robotic or laparoscopic methods, but these methods are out of the scope of this article.

4. Being a descriptive review, the limitations of the review to be listed

Response: As this article is a minireview (commentary for the CONNECT-C trial), I did not list the limitations. However, I described the need for further studies in the last paragraph of “Difference in the effect of CWL in esophageal and gastric ESD” section of the original manuscript as follows: Further studies should be performed to assess the impact of traction direction in traction-assisted ESD.

5. Tabulating the analyzed studies would give a clear overview

Response: Thank you for your suggestion. The main purpose of this article was to introduce the significance of the CONNECT-C trial; therefore, a table for all studies was not

included in this manuscript.

6. The articles included are a small number.

Response: I have cited three new references (#3, 4, and 12 in the revised manuscript).

Reviewer #2:

1. Please describe in detail how to select the traction direction.

Response: The clip-with-line (CWL) approach provides traction for the lesion by pulling the line. The direction in which the line is pulled limits the direction of the traction. Therefore, the traction direction cannot be selected in the CWL-ESD approach. Due to anatomical reasons, traction direction in the CWL approach is proximal in the esophagus, and it varies depending on location of the lesion in the stomach. I described these points in the “Difference in the effect of CWL in esophageal and gastric ESD” section of the original manuscript as follows: “Since the stomach lumen is large and CWL can provide the lesion with traction toward the cardia ...” (second paragraph) and “By contrast, the esophageal lumen is narrow and cylindrical. The endoscope position has a limited forward view, and the traction direction is naturally limited to the proximal traction (Figure 2B)” (third paragraph).

To emphasize the limited traction direction of CWL, I have added Figure 3 and an explanation for this point (highlighted in yellow) in the second paragraph of the section “Difference in the effect of CWL in esophageal and gastric ESD” as follows: Since the stomach lumen is large and CWL can provide the lesion with traction toward the cardia, **as the traction direction of CWL is limited to the direction in which the line is pulled;** therefore, the direction of traction in CWL-ESD for gastric lesions varies among the abovementioned five directions based on the lesion location **(Figure 3).**

I have cited the new reference regarding the impact of traction direction (#12 in the revised manuscript) and added the explanation for this reference in the “Difference in the effect of CWL in esophageal and gastric ESD” section as follows: Although few studies have investigated the effectiveness of traction-assisted ESD according to the traction direction, a propensity score matching analysis (42 pairs) comparing S-O clip-assisted ESD and CWL-ESD in the stomach demonstrated that the S-O clip-assisted ESD significantly could reduce the median ESD procedure time (28.3 min vs. 51.0 min; $P = 0.022$) and accelerated the median dissection speed (24.8 mm²/min vs. 17.1 mm²/min, $P = 0.001$)^[12]. In this study, all traction directions in the S-O clip-assisted ESD were vertical whereas only 16.7% directions in the CWL-ESD were vertical, indicating that vertical traction facilitated the gastric ESD better than the other traction directions.

2. Please describe in detail the information of esophageal cancer in this CONNECT-E trial, include the General information of patients, lesion location, size, shape, degree of infiltration, results of endoscopic staining and amplification assessment, pathology, etc.

Response: Thank you for the suggestion. I have added detailed information on the lesion (highlighted in yellow) in the first paragraph of the section “CONNECT-E trial” as follows: Patients endoscopically diagnosed with esophageal squamous cell carcinoma or basal cell carcinoma with a tumor diameter ≥ 20 mm and clinically diagnosed with intramucosal cancer (cT1a) or slightly invasive submucosal cancer (cT1b-SM1) were randomly assigned to the conventional ESD (n = 116) and CWL-ESD (n = 116) groups.

In addition, I have summarized the baseline characteristics of the patients (highlighted in yellow) in the second paragraph of the section “CONNECT-E trial” as follows: Although a statistical comparison of the baseline characteristics of the patients, including age, sex, tumor diameter, tumor location, and macroscopic type, was not performed, the characteristics of all patients were well balanced. The median tumor diameter was 30 mm in the conventional ESD and CWL-ESD groups. There were no significant differences in histologic depth of the tumor between the groups.

No endoscopic staining or amplification assessment was performed in the CONNECT-C trial.

Reviewer #3: This research is exciting. What about the traction device made by the fuji company? Moreover, endoscopists sometimes use other unknown modifications to the traction method, e.g., the 9-shape line used by prof Inoue. Reference no 5 needs is not recent, as mentioned in the manuscript. Can you write a simple explanation of the ESTD procedure?

Response: Thank you for the suggestion. To address this comment, I did a thorough review of the available literature, but I could not find the details on the traction device manufactured by FUJIFILM Medical Co., Ltd (Tokyo, Japan). As suggested, I have added an explanation of the ESTD procedure in the first paragraph of the section “Endoscopic submucosal tunnel dissection—a promising option for managing challenging esophageal lesions” as follows: In ESTD, a mucosal incision is first made on the distal side and then on the proximal side of the lesion to enter into the submucosa. Next, the submucosa under the lesion is dissected from the proximal to the distal side, creating a submucosal tunnel. During submucosal dissection, the lateral position of mucosa prevents the lesion from falling distally. The endoscope inside the tunnel pushes up the lesion, providing traction for the dissection plane and facilitating submucosal dissection. After creating a submucosal

tunnel, the mucosa and submucosa around the submucosal space are dissected to achieve *en bloc* resection.

I have also cited two new references regarding ESTD (#3 and 4 in the revised manuscript).

Reviewer #4: Thank you for inviting me to review this manuscript. The author described 2 essential traction methods to facilitate esophageal ESD which are CWL-ESD and ESTD. The CWL-ESD data presented is promising in reducing ESD procedure time and the risk of perforation. Figures 2A-F are useful to demonstrate the direction of traction during ESD. ESTD is useful in circumferential lesion. I enjoyed reading the manuscript and I agree this paper will be useful for endoscopists doing advanced endoscopic resection or dissection especially esophageal ESD.

Response: Thank you for your comments.

(1) Science editor: The manuscript has been peer-reviewed, and it is ready for the first decision.

Response: Thank you for your cooperation.

(2) Company editor-in-chief: I have reviewed the Peer-Review Report, full text of the manuscript, and the relevant ethics documents, all of which have met the basic publishing requirements of the World Journal of Gastrointestinal Endoscopy, and the manuscript is conditionally accepted. I have sent the manuscript to the author(s) for its revision according to the Peer-Review Report, Editorial Office's comments and the Criteria for Manuscript Revision by Authors. Please provide the original figure documents. Please prepare and arrange the figures using PowerPoint to ensure that all graphs or arrows or text portions can be reprocessed by the editor. In order to respect and protect the author's intellectual property rights and prevent others from misappropriating figures without the author's authorization or abusing figures without indicating the source, we will indicate the author's copyright for figures originally generated by the author, and if the author has used a figure published elsewhere or that is copyrighted, the author needs to be authorized by the previous publisher or the copyright holder and/or indicate the reference source and copyrights. Please check and confirm whether the figures are original (i.e. generated *de novo* by the author(s) for this paper). If the picture is 'original', the author needs to add the following copyright information to the bottom right-hand side of the picture in PowerPoint (PPT): Copyright ©The Author(s) 2023. If an author of a submission is re-using a figure or figures published elsewhere, or that is copyrighted, the author must provide documentation that the previous publisher or copyright holder has given permission for

the figure to be re-published; and correctly indicating the reference source and copyrights. For example, “Figure 1 Histopathological examination by hematoxylin-eosin staining (200 ×). A: Control group; B: Model group; C: Pioglitazone hydrochloride group; D: Chinese herbal medicine group. Citation: Yang JM, Sun Y, Wang M, Zhang XL, Zhang SJ, Gao YS, Chen L, Wu MY, Zhou L, Zhou YM, Wang Y, Zheng FJ, Li YH. Regulatory effect of a Chinese herbal medicine formula on non-alcoholic fatty liver disease. *World J Gastroenterol* 2019; 25(34): 5105-5119. Copyright ©The Author(s) 2019. Published by Baishideng Publishing Group Inc[6]”. And please cite the reference source in the references list. If the author fails to properly cite the published or copyrighted picture(s) or table(s) as described above, he/she will be subject to withdrawal of the article from BPG publications and may even be held liable.

Response: I have confirmed your comments. I have prepared the PowerPoint file for the figures. I have copyrights for all figures in this manuscript.