ANSWERING REVIEWERS

June 03, 2015

Dear Editor,

Please find enclosed the edited manuscript in Word format (file name: 18090-review.doc).

Title: Is endoscopic re-evaluation needed for "difficult" benign colorectal lesions referred to surgical resection?

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The manuscript has been improved according to the suggestions of reviewers:

1 Format has been updated

2 Revision has been made according to the suggestions of the reviewer and were inserted in the text

(1) Out of the 7 invasive lesions, how many of these were located at the rectum and the colon respectively?

Of the 7 invasive lesions, one was located at the rectum, one at the rectosigmoid junction and the remaining 5 lesions in the colon.

(2) 35mm was used as the dividing line between small and large lesions in this study. What is the proportion of small and large lesions then?

Among the included lesions, 44 (54%) were < 35 mm, while 38 (46%) were ≥ 35 mm in diameter.

Of the resected lesions, 42 (61%) were < 35 mm, while 27 (39%) were ≥ 35 mm in diameter.

(3) In the section of "clinical and endoscopic follow-up", it was mentioned that in patients with pedunculated and semi-pedunculated lesions, surveillance colonoscopy was performed at 12 and 24 months for lesions harbouring low and high-grade dysplasia, respectively. Why were the high-grade dysplastic lesions being followed up later than the low grade dysplastic lesions?

It was just a typing error that I corrected:
In patients with pedunculated and semi-pedunculated lesions, surveillance colonoscopy was performed at 12 and 24 months for lesions harbouring high and low-grade dysplasia, respectively, while in lesions harbouring cancer at 6 and 12 months, and annually thereafter.

Comment: I agree with the authors that the associated cost and complication rate of ESD is higher than conventional EMR. However, it's rather difficult to assess the depth of submucosal invasion after piecemeal removal. All the 7 patients confirmed to have invasive lesions in this study were subjected to

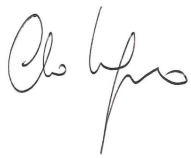
surgical resection after endoscopic treatment. Though the surgical risks and functional outcome of most colorectal resections are quite acceptable by patients nowadays, the impact of resection (total mesorectal excision) for lesions located originally at mid or lower rectum is totally different. Therefore, en bloc endoscopic excision followed by full histological evaluation of the depth of submucosal invasion would be highly beneficial for rectal lesions. Surgical resection may not be necessary in lesions with favourable histology and superficial invasion. ESD can definitely increase the rate of en bloc resection.

I agree with the comments of the reviewer.
However we think that in patients with rectal lesions without a suspicion of invasion (kudo pit pattern III/IV) conventional piecemeal EMR can be a good option, while for rectal lesions with a suspicion of invasion (Kudo pit patter V) transanal endoscopic microsurgery (TEM) is the best approach.
Indeed, TEM allows a curative treatment for early rectal cancer, has a potential role for the treatment of more invasive cancer in combination with neoadjuvant therapies and currently is performed routinely under spinal anaesthesia.
In a recent single arm meta-analysis of case series [Arezzo et al., Surg Endosc 2014; 28: 427–38.], that compared ESD with TEM for lesions more than 20 mm in diameter, an R0 resection was achieved by ESD in 74% of patients compared with 89% by TEM. This probably reflected the consistently greater need for further abdominal surgery after ESD, which was as high as 9%, despite the fact that the rate of unpredicted invasive cancers in the two groups was comparable.

3 References and typesetting were corrected

Thank you again for publishing our manuscript in the *World Journal of Gastroenterology*.

Sincerely yours,



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