

To the reviewers,

We would like to thank you for the time taken to review the submitted manuscript “Endoscopic Management of Intra-gastric Balloon Related Gastric Outlet Obstruction – A Case Report and Review”. Please find below a point by point response to your queries and suggestions;

This manuscript is describing an uncommon problem of intra-gastric balloon displacement or migration to the pre-pyloric region which carries the risk of gastric outlet obstruction or passage to the small bowel with more distal obstruction. This complication was more commonly seen with the more widespread use of this modality. The displaced Balloon should be described in details including the manufacturing company.

- The manufacturing company of the balloon implicated in the case report is listed as the Silimed intra-gastric balloon.

What is the size of the displaced balloon after migration to the prepyloric area?

- Unfortunately the size of the displaced balloon could not be quantified endoscopically, however approximately 500 mLs of methylene blue was aspirated from the balloon periprocedurally. This does not take into account leakage from the balloon after the initial puncture.

How many Milliliters injected in the balloon?

- The balloon was inserted at a separate overseas institution for which the endoscopic report was not available at the time of the patient’s procedure. Given this, the details of the initial insertion, particularly the location and amount of fluid injected were not included in the presented case report. At least 500 mLs of

methylene blue was aspirated from the balloon however periprocedurally which is included in the case.

Did you mix the injected fluid with methylene blue? If so, did the patient noticed bluish discoloration of the urine before aspiration and balloon removal.

- This case report does not detail the injecting of the balloon and initial placement. The balloon was intact at the time of aspiration and removal, as such the patient did not notice discoloration of her urine given the context of the balloon had remained in situ.

Intragastric balloon migration may be diagnosed and followed up by Trans-abdominal Ultrasound. To avoid and early detect this complication, you should suggest a protocol for follow up after balloon application for early detection of complications as Balloon migration or even gastric ulcerations and the possible rare but serious complications. This follow up protocol will help to avoid the unusual but serious adverse events.

- The authors acknowledge this comment and have included a further reference with paragraph in the discussion section of the manuscript regarding surveillance post IGB insertion.

Finally the included articles and included patients is a small number after exclusion of a large number of articles.

- The authors acknowledge this comment. We initially began with a large number of articles using the search terms to ensure we captured all cases of intragastric balloon related gastric outlet obstruction. Although the final number of articles is small, it does highlight the largest review of intragastric balloon related gastric outlet obstruction in the literature.

EMBT should be replaced by EBMT.

- The authors acknowledge this mistake and have rectified it.

Figure 3B has poor resolution, should be improved.

- Unfortunately due to issues with the endoscopic photo acquisition, this was the best photo that was able to be obtained during the procedure. If the reviewers believe that it should be removed and only Figure 3A be included, the authors are happy to facilitate this.

The authors once again thank the reviewer for their recommendations and hope that the resubmitted article is sufficient for publications.

Kind regards,

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