Dear Prof. Hsin-Chen Lee and Dimitrios H Roukos,
Editors-in-Chief,
World Journal of Gastrointestinal Oncology

We are very pleased to have a chance to revise our manuscript (NO 37393: Sessile serrated adenoma detection rate is correlated with adenoma detection rete) with very helpful comments from reviewers. According to the advice, we revised our manuscript.

Point-by-Point Reply
Reviewer#1
1) In the Abstract section the Authors should clearly state that it was a retrospective study.
Re: According to your comment, in the abstract section we added a sentence that this study was a retrospective study

2) The Authors should spend time to explain the relatively low rate of high-grade dysplasia (HGD) (2.2%) and SSAs (1.8%).
Re: As for SSA, we discussed that issue in the discussion section. As for HGD, one reason for relatively low rate seemed to be the difference in the pathological criteria. In Japanese pathological diagnostic criteria carcinoma is diagnosed based on structural and cellular atypia irrespective of invasiveness. Therefore, intramucosal cancers in the present study might be classified into HGD based on the Western pathological criteria.

3) How many pathologists were involved in the study?
Re: Nine pathologists were involved in present study.

4) They should briefly discuss why the mean withdrawal time ≥ 8 minutes was not associated with a better ADR and SSA detection.
Re: We demonstrated that the mean withdrawal time ≥ 8min was significantly associated with better ADR in the result section. As for the correlation between the mean withdrawal time and SSADR, we discussed the issue in the discussion section and we speculated that the small number of total SSAs was the reason.

5) The Authors should spend time to discuss in more detail the major limitations of the study (first of all retrospective study, single centre, relative small sample size).
Re: In the discussion section, we listed the limitations of the present study.

6) As mentioned by the authors, the high rate of surveillance colonoscopy is a clear confusing factor, therefore it would be interesting to re-calculate the results without surveillance colonoscopy, taking in consideration just patients with initial screening colonoscopy.
Re: Thank you for your advice. However, as we cited, Rex et al. has recently reported that using overall ADR to calculate ADR from screening, surveillance, and diagnostic colonoscopies would be just as effective as a screening-only ADR. SSADR in the only screening colonoscopy cohort would be a next exciting issue , but we think our present analysis has also a meaning.

Reviewer2
The study addresses a relevant topic and the paper is well written. However, there are concerns about the methodology of this paper. This is a retrospective study and has the limitations associated with them such as uniformity of observation and data collection and missing data. For example, they have assumed polyps with missing histology or unresected polyp as being non-neoplastic which may not be appropriate. The study participants are heterogeneous and 35.1% patients had 'others' as indication for colonoscopy. As colonoscopy is a commonly performed procedure (the data in this study was collected over just 1 year) , this study can be done prospectively with standard protocol and uniform data collection in a homogeneous group of patients.
Re: We appreciated your critical review comments. We are planning to conduct such a kind of study as you mentioned.

Reviewer3
1) In the authors classification did they come across traditional serrated adenomas TSA ?
Re: We also evaluated TSA and we found only 15 TSAs during the study period. TSA is classified into serrated lesions, but in the present analysis we focused especially on SSA and the total number was so small, and so we omitted TSA.

2) What about hyperplastic polyps were they ignored on size alone?
Re: Generally in our institution small hyperplastic polyps are observed and not resected. Each endoscopist in our institution tends to judge whether they should resect hyperplastic polyps or not based on its size ( ≥ approximately 5mm).

3) Was the NICE classification used by the endoscopist?
Re: We often used a maginification colonoscope, and at that time we used JNET classification, which is the classification concerning magnified colonoscopy with NBI. When we used non-magnification colonoscopies, we diagnosed colon polyps based on the chromoendoscopy findings and NBI.

4) Authors should elaborate on the "other indications for colonoscopy in a table as the numbers are large. pictures both of the histological classification and endoscopic appearance should be included
Re: According to your advice, we included typical endoscopic and histopathological pictures of adenoma and SSA in the manuscript. In our institution colonoscopy indication varies: screening before surgery or chemotherapy, patients' desire, and so on. And it is difficult to classify these indications into each category. We added an explanation concerning 'others' indication in the Table 1 as a footnote.

Reviewer4
As above
Re: Thank you for reviewing our manuscript.

Revierwe5
Dear Sir, Thank you for letting me be part of your team. I think that this manuscript can be send to be published after they clarify some points of the description of the serrated polyps. Thank you Sincerely
Re: Thank you for your encouraging comment.