P2 L9:

Q: You start with an intervention, EMR, and then see what happens, prospectively.

A: Thank you for your advice. We totally agree that a prospective series would be more advantageous here but this would need a large scale multicenter trial as these patient numbers are usually small. We are in the process of a CRUK grant to look at this over 6 UK sites in a prospective study.

P3 L18:

Q: What figures?

A: Please accept our apologies – we have added the low risk of LNM and surgical mortality at 1-2% in the text and highlighted for clarity. We hope you will find this acceptable.

P3 L20:

Q: And your results support this approach

A: We hope so and thank you for your support. We believe that LR T1b patients should be offered EET routinely.

P3 L25:

Q: What is the alternative if the patient is unfit for surgery, other than conservative approach? The question is if even fit patients benefit from conservative treatment.

A: Thank you for your comments. The alternative to surgery if the patient is unfit is to either have clearance of the residual metaplastic or dysplastic BE with more EMR or RFA OR to have endoscopic surveillance at practical intervals to then treat a "pop up" lesion should one appear.

As you correctly point out even in fit patients the conservative strategy has been adopted where patient preference or even clinical advice may supersede the decision for surgery.

We agree that a potentially valuable study would explore whether fit patients could be offered conservative treatment. We are in the process of trying to establish this study and believe this to be a potentially viable option. It is, however, outside the remit of this work.

We hope these comments answer your query.

P3 L33:

Q: High volume Tertiary referral centre? Do you have the number of patients that went straight to surgery (no EMR) with T1b?

A: We do not have these data to hand as all the early stage cancers would have had EMR/ESD at our center. We have looked at all the T2 cancers that were sent for surgery based on baseline staging and none of these were subsequently down staged to T1b cancers.

P3 L35:

Q: How many EMR with LNM present from the beginning? Describe your work-up before EMR is performed (EUS, CT, PET before?)

A: We have added to the text that any LNM on EUS, CT or PET CT would exclude EMR. We hope this has helped.

P4 L14:

Q: Would have been nice if this third expert reviewed all 60. Afterall; histopathology is the most important factor for evaluating risk for LNM after EMR

A: We agree with your suggestion. Unfortunately at this present time to get a 3rd pathologist to review all these slides would not be practical but we will build this in to the future prospective study. Thank you for your very practical suggestion

P5 L21:

Q: Maybe use disease-specific and overall survival?

A: Thank you for your suggestion. When we asked colleagues to review this manuscript they found this terminology clearer. However, we agree that this is an alternative

P5 L30:

Q: i.e. 68 T1b´s in total during 8 years? How many EMR´s on BE performed?

A: In our unit we carry out on average >100 EMRs on new patients per year. During the study period we estimate that we carried out at least 800 EMRs on patients with BE

P5 L31:

Q: How many LNM among these 6?

A: Of these 6 patients, one was a T2 cancer but the other 5 had no evidence of LNM with the follow up duration to hand and date available

P6 L2:

Q: Would be nice with some description of performance status (ECOG/WHO)

A: Thank you for this suggestion. Unfortunately, we do not have that data at hand at present and the practicalities of obtaining now would be very time consuming. However, this is an excellent suggestion and we will adopt this for future work.

P6 L3:

Q: Five patients with cardia cancer, by definition not BE or OAC. Should be excluded?

A: Thank you for your comment and we apologise for the lack of clarity. Each of these cardia lesions were Siewert 1 lesions and the patients all had long BE segments (>3cm). As such we felt it reasonable to include them. We have altered the table for clarity.

P6 L14:

A: This has been changed to T3. Please accept our apologies

P7 L8:

Q: That is five. What about patient number six?

A: We apologise for this error. This has been added.

P7 L9:

Q: How did you detect, and verify LNM in each of the six?

A: We have added this information to the text

P7 L26:

Q: Definition of long term? 60months?

A: Our inclusion criteria required patients to have follow up of at least 24 months prior to inclusion, The median follow up was 45 months and therefore this was regraded ad long term.

P7 L34:

Q: I think you should exclude LR, and then compare treatment modalities for survival.

A: Thank you for your comment. This has been addressed now here.

P8 L11:

Q: What do you mean with M3?

A: We use the description of the mucosa being divided into 3 layers M1/2/3.

Prevalence of lymph node involvement based on depth of tumor

	T1a			T1b		
	m1	m2	m3	Sm1	Sm2	Sm3
Rice[b] *et al.* [8] ($n=122$)		2% (2/91)			19% (6/31)	
Liu[b] *et al.* [9] ($n=90$)		4% (2/53)			27% (10/37)	
Cen[b] *et al.* [10] ($n=99$)		4.2% (2/48)			23.5% (12/51)	
Altorki[a] *et al.* [11] ($n=75$)		6.7% (2/30)			17.8% (8/45)	
Sepesi[b] *et al.* [12] ($n=54$)		0% (0/25)		21% (3/14)	36% (4/11)	50% (2/4)
Westerterp[b] *et al.* [13] ($n=120$)	0% (0/13)	0% (0/18)	4.3% (‖1/23)	0% (0/25)	26% (6/23)	66.7% (12/18)
Shimada[a] *et al.* [6] ($n=160$)	0% (0/9)	0% (0/12)	1.6% (1/60)	32% (8/25)	31% (10/32)	42% (28/66)
Ancona[a] *et al.* [14] ($n=98$)	0% (0/3)	0% (0/12)	0% (0/12)	8.3 (3/36)	28.6% (2/7)	53.6% (15/28)
Barbour[b] *et al.* [15] ($n=85$)		0% (0/35)		17% (2/12)	12% (2/17)	20% (4/20)
Leers[b] *et al.* [16▪] ($n=126$)		0% (0/18)	1.3% (1/57)	21% (4/19)	11.1% (1/9)	26.1% (6/23)
Holscher[a] *et al.* [17▪] ($n=171$)	0% (0/25)	0% (0/10)	0% (0/35)	13% (4/30)	19% (5/26)	56% (25/45)

[a]Adenocarcinoma and squamous cell carcinoma.
[b]Adenocarcinoma only.

P8 L18:

Q: Strange sentence. You can´t count dead patients as alive.

A: Thank you for your comment. I think you have mis-read this sentence.

P8 L30:

Q: After this statement, I think you can conclude that the risk of LNM is 20% (to answer to the primary endpoint and Title) for HR T1b, and that the long term survival is poor (only one survived 5y. You should then exclude all LR from the analysis, and focus on HR. Surgery vs conservative treatment.

A: Thank you for your comment. You will note that the first sentence in the next

paragraph states the LNM risk (18%) in HR lesions.
We have added in the survival data to the main text and emphasised that of those with HR lesions 70% were alive at the end of the study.

P9 L5:
Q: What kind of studies? Prospective? RCT?
A: We have added this here

P9 L33:
Q: As we always do in T2-3
A: We agree with your comments