

Reviewer #1:

1) Please explain the indication of endoscopic methods (dilation and stent) for the treatment of benign stenosis and RBES.

Revise: Dilation was the standard treatment for all benign stenosis patients, with other alternatives, such as stents placed on a case-by-case basis at the discretion of the endoscopist performing the procedure, after an appropriate discussion with surgeons and a dietician, as needed. The amendments have been made to the manuscript text and these can be viewed at Equipment and procedure, line 12, page 5.

2) 1146 patients had been treated by endoscopy for benign esophageal stricture, but only 507 had been enrolled into final analysis. Please specify, why 639 patients had been excluded from the analysis.

Revise: It can be seen in the figure 1. 1146 patients with esophageal stricture had been treated by endoscopy. 639 Patients were excluded if they (1) had been diagnosed with congenital esophageal strictures, malignant esophageal strictures (n=342), or with esophageal fistula (n=94), (2) were diagnosed with recurrence of esophageal cancer (n=29), (3) had lost follow-up (n=95), or had incomplete data (n=21). These can be viewed at Patients, line 10, page 4.

3) Please explain in detail, how were created Development and Validation cohorts for risk-scoring model for predicting of RBES in benign esophageal strictures.

Revise: These can be viewed at Statistical methods, line 5. Briefly, using a random number from the Uniform (0, 1) distribution, we labeled those with values  $<0.3$  as the validation cohort and  $>0.3$  as the development cohort, this gave us a 70/30 split. This split-sample strategy has been used in multiple models. In the development cohort (70%), we tested candidate variables and retained the statistical significance in multivariate binary logistic regression analysis. In addition, multivariate binary logistic regression analysis, with the corresponding odds ratios (OR) and 95% confidence intervals (CI), was performed to identify the independent risk factors for RBES. A scoring model was developed to calculate the probabilities of RBES in benign esophageal strictures patients on the basis of the retaining candidate variables. The independent risk factors were selected as scoring items, and the score of each risk factor was weighted according to the beta coefficient obtained from the logistic regression model. The respective beta coefficient was rounded to the nearest whole number to keep the scoring model simple. The total score for each patient represented the sum of scores for each risk factor. Using these scores, we derived 3 groups of risk: low (points 0-2), intermediate (3-5), and high (6-8). Probabilities of RBES with 95% CI in each group, stratified by the risk factor, were calculated. In the validation cohort (30%), the model discrimination was tested with the receiver operating characteristic (ROC) curve and area under the ROC curve (AUROC).

4) The risk score ranged from 0 to 9 points. Patient could get 1 point for age, 4 points for etiology, 1 point for number of strictures and 2 points for length of strictures, which is a maximum of 8 points, see Table 4. Please explain how to score 9 points?

Revise: Thank you very much. In the last step of calculation, there was an error in drawing the table because it was not updated in time. Now the table has been recalculated. The amendments have been made to the manuscript text and these can be viewed at Table 5.

5) Please edit the references.

Revise: Thank you very much. We have edit the references.

6) English language polishing is needed.

Revise: Thank you very much. We used English language editing service to copy-edit the paper again. Thank you very much.

Reviewer #2:

As they indicated it, their study was a single-center design with a retrospective manner, and had a potential selection bias. The authors would better show the cascade how they chose the treatment plan.

Revise: Thank you very much. Dilation was the standard treatment for all patients, with other alternatives, such as stents placed on a case-by-case basis at the discretion of the endoscopist performing the procedure, after an appropriate discussion with surgeons and a dietician, as needed. The amendments have been made to the manuscript text and these can be viewed at Equipment and procedure, line 12, page 5.

And also, they should show some data at the result part instead of the discussion part. Finally, there are several presenting errors at tables to be corrected.

Revise: We should show more data at the result part instead of the discussion part. The amendments have been made to the manuscript text and these can be viewed at Table 5.

Reviewer #3: The study seems statistically well conducted. It deals with a very interesting topic. By the way, the authors' results meet the typical findings of the daily practice. The difference is that, thanks to this work, risks factors are statistically proven. I also would like the authors to define if their findings have an impact on daily practice or not. For instance, do the presence of a bad or score modify the endoscopic (dilatation vs stenting) and/or surgical indication? If so, your work could have a stronger impact on literature. I presume that probably your score does not modify daily clinical behaviour since at the end, oesophageal dilation is always the first attempt to do, even in the stenosis with bad prognosis. Therefore, I have some concerns on the usefulness of your work.

Revise: Thank you very much. The risk-scoring model predicting RBES in benign esophageal strictures could predict the long-term outcome of patients with strictures ahead. Our findings may have an impact on daily practice. The presence of a bad score means surgical indication and refractory to endoscopic therapy. But the present study is a retrospective study to develop and validate a model. In the future, case control studies and prospective studies are considered necessary.

The work must be revised by a proficient English author. Also please avoid contracted forms (e.g. "didn't"): this is a formal academic work and not a conversation among friends.

Revise: Thank you very much. We used English language editing service to copy-edit the paper again. Thank you very much.