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ANSWERING REVIEWERS

We have examined this review article. The authors describe their work as a comprehensive review.
Please describe what steps were taken to evaluate literature to be included in this comprehensive review.

The core tip has been revised as the following to meet the journal's requirements:

This review summarizes the natural history of inflammatory bowel disease associated dysplasia and colorectal cancer. An up to date review of risk factors for inflammatory bowel disease associated colorectal cancer is included. Highlights include surgeon specific factors to aid in joint decision making with the patient regarding further management of their disease. These factors include the management options of continued appropriate endoscopic surveillance and the different disease specific surgical options. Finally, it summarizes the long-term surveillance program and the long-term prognosis following surgery for inflammatory bowel disease associated neoplasia.

Introduction, page 4, paragraph 2: "IBD-CRC arises from dysplasia in flat mucosa" but then on page 6 under "Natural history of", one sees "recent data suggests that sequential progression from inflammation to LGD ... does not always occur". I certainly agree with page 6, and so I would be more conservative about the descriptions on page 4. Bob Riddell's work in this field and the question of an absence of progression from dysplasia in ulcerative colitis began in 1974 (Gut; 15: 822-41). Absence of progression is not a recent idea (page 6 under "Natural history").

The sentence in page 4 has been revised as the following:
In contrast to sporadic CRC ~~which arises from the adenoma carcinoma sequence,~~ IBD-CRC arises from dysplasia in flat mucosa which is difficult to identify during endoscopic examination.

Page 6: "dysplasia in IBD is being detected more and more"; please rewrite sentence and provide a reference for this statement.

The sentence was rewritten as the following:

Currently, detection of dysplasia in IBD has increased ~~is being detected more and more~~ with the use of high definition endoscopes[25].

In Screening guidelines, page 10; clearly chromoendoscopy with targeted biopsies can't or won't occur nationally or internationally. Please comment on the difficulties initiating this guideline.

Please comment on the potential effect of this guideline on colectomy rates.

The following paragraph was added to address the difficulties in initiating the endoscopy guidelines:

However, there are some concerns regarding the use of chromoendoscopy which could be a potential barrier to the initiation of these guidelines. These concerns include the need for advanced training in this technique and the development of quality metrics to assess performance after training. Furthermore, chromoendoscopy requires additional preparation and procedure time. Finally, there is an increased facility and provider cost with no procedure specific code for reimbursement[24].

With improvements in endoscopic imaging, more dysplasia will be visible. According to the SCENIC guidelines, continued surveillance colonoscopy is recommended rather than colectomy following complete removal of both polypoid and non-polypoid dysplastic lesions. It is expected that the threshold for colectomy will increase from both patients and physicians perspectives. Of note, in a survey to evaluate patient preferences for colectomy or surveillance in the presence of dysplasia, Siegel et al found that 60% of the patients will refuse colectomy if they were told that the CRC risk is 20%. On average, patients would agree on colectomy if their risk of CRC was 73%[50].

Page 10-11 "Dye-based"; "a 7% difference"; in what, authors please specify.

In this group of patients, there was noted to be a 7% difference in the detection of dysplasia that favored chromoendoscopy over standard white light endoscopy.

Page 13, Strictures: "If a known stricture ... completely evaluated by biopsy". How would you know whether it had or had not been "completely" evaluated? Completely sounds like transmural specimen is required. How can you reliably distinguish benign from malignant strictures in ulcerative colitis (see for example SJM Goulston, NEJM 1969; 281: 290-5).

The following changes were made to address this comment:

In UC, stricture formation is believed to result from contraction and hypertrophy of the muscularis mucosa[67]. Regardless if the strictures are symptomatic, in the setting of UC, endoscopy and biopsy should be performed to evaluate for neoplasia[54]. Strictures in the presence of UC are associated with 30-fold risk of CRC and in the presence of CD, a 3-fold increased risk of CRC [68]. To evaluate a stricture, it must be fully traversed by the endoscope and adequately biopsied[69]. If complete

evaluation cannot be performed by endoscopy and biopsy, surgery should be strongly recommended[54] .

P 15, risk of adenocarcinoma in retained rectum: please comment on the risk of recurrent bleeding from retained mucosa and its evaluation/treatment.

The following changes were made to address this comment:

Moreover, inflammation of the retained rectal mucosa (cuffitis) can occur following surgery in about 15% of patients. Only small number of patients become symptomatic with symptoms of increased bowel movement, abdominal pain, tenesmus, and rectal bleeding[79,80]. In a series of 61 patients who underwent RP for UC, Shen et al[81]found that only 4 (6.5%) patients who developed cuffitis had rectal bleeding. All patients responded to 2-week medical treatment with topical mesalamine or hydrocortisone without the need for surgical intervention[81]. Patients with cuffitis will have an inflamed rectal cuff seen on endoscopy with ulceration and neutrophil infiltration in biopsy, the pouch mucosa is typically normal with no signs of inflammation[81].

Then page 15, Next line, "infact" should be "in fact".

Corrected

Page 16, complications of restorative proctocolectomy; please make a table.

Done (Table 4)

P 17,"Surgical options for": authors, please clearly discuss potential risks, evaluation of, and management of long standing terminal ileal stricture in Crohn's disease and adenocarcinoma.

This is discussed under *Strictures* (page 14-15)

Data top of page 19 (Neoplasia and risk factors): authors, please make a table.

Done (Table 5)

Page 20, "Prognosis and long-term": authors, please make a table.

Done (Table 6)

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ESPS PEER-REVIEW REPORT

Name of journal: World Journal of Gastroenterology
ESPS manuscript NO: 22035
Title: Inflammatory Bowel Disease Associated Neoplasia: A Surgeon's Perspective
Reviewer's code: 00503587
Reviewer's country: New Zealand
Science editor: Yuan Qi
Date sent for review: 2015-08-11 17:41
Date reviewed:2015-08-25 16:47

CLASSIFICATION	LANGUAGE EVALUATION	SCIENTIFIC MISCONDUCT	CONCLUSION
[Y] Grade A: Excellent	[Y] Grade A: Priority publishing	GoogleSearch:	[ ] Accept
[ ] Grade B: Very good	[ ] Grade B: Minor language polishing	[ ] The same title	[ ] High priority for publication
[ ] Grade C: Good	[ ] Grade C: A great deal of language polishing	[ ] Duplicate publication	[ ] Rejection
[ ] Grade D: Fair	[ ] Grade D: Rejected	[ ]Plagiarism	[Y] Minor revision
[ ] Grade E: Poor		[ ] No	[ ] Major revision
		BPG Search:	
		[ ] The same title	
		[ ] Duplicate publication	
		[ ]Plagiarism	
		[ ] No	

COMMENTS TO AUTHORS

This review focuses upon key aspects of IBD-associated cancer. It is clear, direct and well-written. The first section of the Introduction includes a number of statements that are unreferenced. Addition of relevant references would be helpful

Done

The Legend for Table 2 should be enhanced (to make this more independent)