Peer Review File

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Reviewer A

Comment 1: Your case demonstrates success of endoscopic treatment in selected cases. Given the success of its technique, a broader description of the used cutting snare would be desirable.

Reply 1: The Snaremaster™ 20 x 0.48 mm electrosurgical snare was used in this case
Changes in the text: This information was added, please see page 3, lines 17-19

Reviewer B

Comment 1: This is a well written paper, highlighting the rare presentation of gallstone sigmoid ileus in an 88 year old man.

There is a relative paucity of existing data on this subject and this case outlines a conservative approach to a potentially life-threatening condition. This resulted in expedient discharge home on day 1 post procedure. The images nicely demonstrate the underlying condition. However, this type of case and management strategy has been reported before.

The authors do not make clear the unique modality or presentation of this case. I would urge the authors to review/cite the systematic review by Farkas et al. on this subject; https://www.sciencedirect.com/science/article/pii/S2049080118300098

This may serve as a reference by which this case can be compared to. I would ask the authors to state whether there was any evidence of diverticular disease or stricturing of the colon. A 2.6cm stone is relatively small to obstruct a large bowel lumen without the presence of other pathology. This aspect should be highlighted.

Reply 1: This review paper highlights that management strategies vary considerably and that there is no currently no management consensus in the literature with regard to conservative approach versus surgical intervention. The article reports that conservative management successfully treated 26% of patients and 74% ultimately underwent surgical intervention. They conclude that endoscopy and lithotripsy are practical first line strategies. Our case report helps exemplify this fact; conservative treatment should always be attempted first if the patient is stable without concern for perforation on presentation.

Based on previous reports, diverticular disease is a common co-morbidity in patients found to

have colonic gallstone ileus. However, in our case, the patient had no evidence of diverticulosis or stricturing of the colon. He was found to have a tortuous sigmoid colon with an acute angle at the rectosigmoid junction that the stone could not traverse.

Changes in the text: The article and its findings were referenced, please see page 5, lines 2-6. We also included that our patient did not have any evidence of diverticular disease on colonoscopy, however he was found to have a tortuous sigmoid colon with an acute angle at the rectosigmoid junction that the stone could not traverse; please see page 3, lines 14-16.

Comment 2: The last paragraph in the discussion relating to fistula formation should be revised/ removed. Cholecystocolonic fistulas require multiple attacks of cholecystitis and years to form. It is highly unlikely that the decreased nutritional status precipitated the formation of the fistula in 6 months.

Reply 2: Thank you for this comment, this sentence was removed from the manuscript

Comment 3: Similarly, the stroke which is mentioned in the case presentation is an important factor to consider when determining management. The patient will likely be on anticoagulation and therefore at higher risk for more invasive management. Was any risk stratification undertaken? Will the patient be considered for elective cholecystectomy if recurrent bouts of cholecystitis? Please add to discussion/presentation.

Reply 3: The patient was on aspirin prior to presentation. No risk stratification was performed, as the patient was stable and initially taken for colonoscopy. If the patient required surgical intervention, risk stratification would have been pursued. Given the patients age (88 years) and medical co-morbidities, the patient and his family did not wish to proceed with any additional surgical intervention. If he were to present with concern for cholecystitis, patient would have a cholecystostomy tube placed to decompress the gallbladder over surgical intervention based on patient and family wishes.

Changes in the text: This information was added to page 5 lines 21-23 and page 6, lines 1-2

<u>Reviewer C</u>

Comment 1: 41: abdomen was distended, 47: Nil by mouth (NBM) or Nil per oral (NPO), 76: development of cholecystocolic fistula

Reply 1: Thank you for these grammar errors, they have all been modified in the text
Changes in text: Page 3, line 3; page 3 line 8; page 4, line 14

Comment 2: If the stone was removed endoscopically what happened to fistula? Was fistula repair planned?

Reply 2: Based on the patients age, medical co-morbidities and family wishes there is no plan at this time for him to undergo surgical intervention to take down the fistula or remove the gallbladder
Changes in text: This information was added to manuscript, please see page 5, lines 21-23 and page 6, lines 1-2

Comment 3: Patient attended gastroenterologist second time: that history needs more information details. E.g., repeat scan showed choledocholithiasis, was it present during first presentation? If not, why did he develop that in a 3 month period.

Reply 3: On presentation, in addition to a CT scan the patient had an abdominal ultrasound which demonstrated collapsed gallbladder with no biliary duct dilation or concern for choledocholithiasis. Three months later the patient was seen by the gastroenterologist for persistent abdominal pain and found to have choledocholithiasis on MRCP. We did not suspect choledocholithiasis on initial presentation due to imaging findings and normal LFT's and bilirubin. In retrospect, we could have obtained MRCP prior to discharge to rule out choledocholithiasis.

Changes in text: The fact that an ultrasound was obtained during initial presentation with no concern for choledocholithiasis was added to manuscript, please see page 3, lines 10-12

Comment 4: Would be good to add post procedure images to compare

Reply 4: Thank you for this comment, postop CT scan image added
Changes in text: CT scan post procedure was added (please see figure 3). This demonstrates persistent cholecystocolonic fistula with evacuation of gallstone from the colon.

Comment 5: If patient did well was there any plans for him to undergo fistula repair?

Reply 5: Based on the patients age, medical co-morbidities and family wishes there is no plan at this time for him to undergo surgical intervention to take down the fistula or remove the gallbladder
Changes in text: This information was added to the manuscript, please see page 5, lines 21-23 and page 6, lines 1-2