Peer Review File

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Reviewer A

Comments to the authors:

- Introduction section. I suggest to include small paragraph about the prevalence of inflammatory bowel disease in the general population Also by the ethnicity

We add data on the incidence of IBD in different areas of the world as well as by ethnicity.

- Epidemiology section. What about the risk of CRC in patients with both inflammatory bowel disease and scleorisng cholangitits?

We include data for CRC in IBD and PSC with IBD in epidemiology.

- Pathogenesis section. I suggest to include the role Microbiota in CRC

We include the role of oncogenic and protective microbiota in risk factors.

- I suggest to include in the end the text a conclusion section or future research in this area
We include fecal and serological biomarkes and confocal laser miscroscopy in a new section Future Research in CRC and IBD.

Reviewer B

Comments to the authors:

Abstract:

- Ulcerative Colitis, Adenocarcinoma and Crohn´s Disease; capital letters; these should be change.

We change capital letters

- **PSC: this word must be removed, as thus is not in the abstract again.**

We remove PSC from the abstract.

Introduction:

- Line: 47: Ulcerative Colitis, Crohn´s Disease and Inflammatory Bowel Disease: capital letters; these should be change.

We remove capital letters.

- In risk factors: What about pseudopolyps?
We talk about pseudopolyps in anatomical abnormalities.

- Line 61: It is important to know the aim of the study.

We include the aim in introduction: The aim of this review was to show the evidence found in the literature on CRC, recommendations and their impact on IBD patients.

- An important point: What were the search methods in this article?
We include a new section of research methods.

- Change the word: doctors. Maybe providers
We change the word for physicians.

Epidemiology:

- There is lot information from different countries, some of them quite old (2001), The authors should check the paragraph?

We remove old references and add new information of recent years.

- Line 66; it's important to know the interval confidence of the study.

We replace this article por a new recent one.

- Line 85; In the male gender, is the incidence higher due to the disease or the same as the general population?
Is the same for patients without IBD.

- Line 86; (IRR) it's the first time in the text, the complete sentence must be first.

We remove IRR (internal rate of return).

- Line 90; review writing.
This line was deleted.

- Line 92; "sometimes be an incidental finding during a surgical procedure for a symptom unrelated to neoplasia or spontaneous perforation".

It was clarified that this happens in a small group.

Pathogenesis:

- Line 98- 100; "Several factors that contribute to the development of neoplasms in IBD include chronic inflammatory processes, the body's response to these processes, genetic alterations, oxidative stress, among others".

We include risk factors as microbiota, disease duration, extent of disease, PSC, young age at diagnosis, anatomical abnormalities, family history of CRC.

- Change the words: body's response. This expression sound too colloquial.

We rewrite this line and change the word for immunological response.

- How about the microbiota?

We add a microbiota section in risk factors.

Genetics: It is necessary to rewrite this paragraph.

We rewrite this paragraph for a better understanding.

Risk Factors:

- It would be more structured if patients related and disease related factors are described.

Patients risk factors: increasing age, prior history of CCR, in first degree relative (especially if is under 50ths, PSC).

Disease risk factors: extensive colitis, duration, severity of inflammation, early onset of the disease, anatomical abnormalities such as stenosis and pseudopolyps.

We describe risk factors in two groups, patients and disease risk factors for CRC.

Disease duration:

- When would you start surveillance? 8-10 years of disease? How about in proctitis?

The general recommendations is to start surveillance at an average of 8-10 years from the diagnosis of the disease in people without any risk. Patients with proctitis do not need closer surveillance.

Extent of disease:

- Line 138; put a reference.
We include a reference.

- What is the role of endoscopic and histologic remission?

We include this section in the text of the benefits of histological remission that is a new goal in treatment with better results than endoscopic remission, with a decreased risk for CRC.

Primary sclerosing cholangitis:

- Line 140: Excess (capital letter)

We remove capital letters.

- IBD – PSC phenotypes: (it´s important to remark→ frequently characterized by pancolitis, rectal sparing, and possibly backwash ileitis.

We include this phenotype in PSC section in risk factors.

- When would you start surveillance?
PSC is a high risk group and need annual surveillance as shown in table 1.

Anatomical abnormalities:

- Line 152; Pseuodopolips → pseudopolyps
We change the word for pseudopolyps

- Line 152-155; rewrite this paragraph.
We rewrite this paragraph for a better understanding.

Family history of CRC:

-Line 159: It is necessary to rewrite this paragraph, it sounds colloquial.

We rewrite this paragraph for a better understanding.

Chemoprevention:

Line 172: "The chemoprotective effect of using5-ASA without PSC has not been studied, and not widely recommended as chemopreventive treatment in the general population or IBD patients". Check the information. If it is correct, you should add a reference.
We change 5-ASA for ursodeoxycholic acid, is the correct word.

"The chemoprotective effect of **ursodeoxycholic acid** without PSC has not been studied, and not widely recommended as chemopreventive treatment in the general population or IBD patients".

Diagnosis and surveillance strategies:

Rewrite the text.

1. Risk factors: high, intermediate and low risk
We include a section of risk stratification.

2. When would you start surveillance?
The surveillance periods are shown in table 1.

3. How about Chromoendoscopy vs HD White Light

We include an article that show that chromoendoscopy has a benefit over standard with-light endoscopy.

4. How about random or targeted biopsies. I there a role of randomized biopsies?
We include an article that demonstrate the benefits of targeted biopsies

5. What is the risk of indefinite dysplasia?

Have a risk of progression of 18-28 and need to repeat endoscopy 3-12 months later with chromoendoscopy.

6. What is about multifocal and unifocal low grade dysplasia?
Multifocal low grade dysplasia is an indication of colectomy and unifocal low grade dysplasia can be treated with local treatment.

Pouch surveillance

- Line 206; proctocolectomy with ileal pouch anal anastomosis (IPAA)

We correct IPAA.

- Cuffitis is the inflammation of the anal transition zone or cuff.
We remove the word cuffitis.

- Risk factors are for pouch cancer.

We change the name section of pouch surveillance for pouch cancer and include surveillance in this area.

- When should considered surveillance?
We include the time to initiate surveillance based on risk factors and the guidelines given by these recommendations.

Endoscopic and surgical treatment.

-When it is possible standard polypectomy should be considered. That´s the main reason for surveillance. Patients with dysplastic polypoid lesions that have been completely resected should undergo close endoscopic surveillance.

We include this terms in endoscopy resection.

-If resection it's not possible in multifocal LGD or HGD colectomy should be considered.

We include this terms in colectomy section.

-Prognostic: rewrite the paragraph. Surgery is being mixed with endoscopic follow-up

We rewrite this paragraph for a better understanding.

Conclusion:

-Write about risk factors, any comment from ECCO or ACG guidelines?

We change conclusion and include risk factors and guideline comments.

Table 1: has the guidelines information but there is no reference in the text.

- What are the variables in high-intermediate- and now risk?

We include a stratification section.

Reviewer C

Comments to the authors:

- Line 27 read: "…in patients with Ulcerative Colitis (UC) and Adenocarcinoma in patients with Crohn´s Disease…"
Please review, maybe it should read: "…in patients with Ulcerative Colitis (UC) and *Small-Bowel* Adenocarcinoma in patients with Crohn´s Disease…"

We change the line for the suggestion.

- Line 37 and 38 read "…endoscopist, but in some cases where endoscopic treatment can be performed or it is not recommended it is preferable to perform surgical treatment, to prevent the development of CCR, …"
Please review, maybe it should read: "…endoscopist, but in some cases where endoscopic treatment *can't* be performed or it is not recommended surgical treatment *may be performed*, to prevent the development of CCR, …

We change the line for the suggestion.

- Introduction

Please consider rephrasing line 47 through 49: "Ulcerative Colitis (UC) and Crohn´s Disease (CD) which are part of Inflammatory Bowel Disease (IBD), are chronic conditions that have a higher risk in the development of colorectal cancer (CRC) and constitutes one of the most frequent causes of death by cancer in the world."

We change the line for: Ulcerative colitis (UC) and crohn's disease (CD) are part of inflammatory bowel disease (IBD), these are chronic conditions, and they have an increased risk to develop colorectal cancer (CRC). This complication is one of the most frequent causes of death related to cancer around the world.

Primary sclerosing cholangitis

- Line 140 read "*PSC, it is considered* an extraintestinal manifestation of the disease…"
Maybe it could read "PSC is an extraintestinal manifestation of IBD…"

We change the line for: Is an extraintestinal manifestation.

- Line 141 read: "is the main mechanism proposed by its effect on cell proliferation in IBD with coexisting PSC".
Please consider rephrasing as the message is unclear.

We change the line for: In patients with PSC, it is the main mechanism since it has an effect on cell proliferation.

- Family history of CRC

Line 159 read: Family history of CRC, it's not the main risk, but it is a factor in the general population"
We delete the line.

- Diagnosis and surveillance strategies

Line 195 reads: "…dysplasia lesion…"

We change the word for dysplastic lesion.

- Endoscopic and surgical treatment

Line 212 reads: "Various strategies are depending on the degree of dysplasia…"
We change the line for: Various strategies are available depending on the degree of dysplasia.

- Conclusion

Please consider rephrasing, the message is unclear.

We change the conclusion and include risk factors and guideline comments.