

Peer Review File

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Reviewer A

- In this article, the definition of large colorectal polyp is unclear. If you define the lesion larger than 10mm, please add the reference.

Reply 1: An exact definition for large colorectal polyps is not clear in the literature. We assume any polyps larger than 10mm as large polyp given the significant risk of malignancy compared to those less than 10mm as further described in the rest of the chapter: "large colorectal polyps and risk of malignancy". This is the same cut off for advanced adenoma size.

Changes in the text: We added a reference to our definition line 150, page 9.
- In introduction, the author states that Paris classification, Kudo pit pattern is important predictor of deep submucosal invasion. Recently, JNET classification with NBI magnification is established as a universal endoscopic classification for colorectal tumor. (Sano Y, et al. Dig Endosc, 2016.) In the West, NICE classification is generally used for NBI classification. Please add to the preface.

Reply 2: Agree. Done.

Changes in the text: We made modification to the introduction to include JNET and NICE as suggested. Lines 115-118, page 8.
- In figure1, piecemeal EMR was recommended for adenoma>30mm. However, piecemeal EMR have a high rate of local recurrence compared to ESD as the author mentioned. In addition, LST-G larger than 3cm, should be considered submucosal invasion. Therefore, ESD should be recommended for large lesions where piecemeal resection was expected.

Reply 3: EMR can be safely done by a wide range of endoscopists either en bloc or piecemeal for LST-G larger than 3 cm. En -bloc EMR for larger lesions >3 cm could increase risk of perforation. ESD is not widely available, however, ESD is also a reasonable option for LST-G larger than 3 cm. ESD on other hand could be time-consuming and has steep learning curve. No prospective RCT has shown either strategy better than the other in terms of immediate or long term outcomes.

Changes in the text: Figure 1 changes to include ESD for lesions larger than 3 cm for select cases.
- ASGE, ESGE, and JGES developed the world's leading guidelines for endoscopic resection for colorectal lesions. Please discuss and add the references.

Reply 4: Thank you, done.

Changes in the text: new paragraph was added lines 194-198, page 11.

Reviewer B

This is a review of the literature on best practices for the management of endoscopic resection of large colorectal polyps. I have some comments.

Major:

- Please refer to the recent papers about UEMR showing higher enbloc and R0 resections rates for intermediate and large sessile colorectal polyps compared to CEMR.

Reply 1: Thank you. Done.

Changes in the text: new lines were added in lines 467-469 page 15 to reflect recent meta-analyses findings.

2. Line 246: UEMR can be used for pedunculated polyps, but the beneficial effect of UEMR compared to CEMR is more evident for sessile rather than pedunculated lesions.

Reply 2: That line is referring to underwater technique used instead of gas insufflation in all polypectomies not just EMR.

Changes to text: This idea was separated to a different paragraph, lines 473-477 page 15 to make it clearer to the reader.

3. Please discuss that UEMR has also been shown to be effective for lesions in difficult locations, such as the appendiceal orifice.

Reply 3: this is added

Changes to text: Added line 470-471 page 15.

4. Please also discuss the limitations of each resection technique as well as complications rates.

Reply: Thank you. We have explained the limitations of each technique throughout the article and summarized in the table. Further discussion is beyond the scope of this invited article.

Changes to text: none.

5. Please specify which lesions suspected of submucosal invasion are likely to be resected by eFTR or ESD.

Reply: Lesions 25-30 mm or suspected submucosal invasion are candidates but as you know the practical applications are much broader for eFTR and ESD.

Changes to text: Refer to changes 492-501, page 15.

6. Please state the recurrence rates of Coldsnare polypectomy compared to conventional EMR for different polyp sizes.

Reply: We have reported recurrence rates for individual methods in Table 1. Cold snare polypectomy is commonly used for polyps 3-9 mm (ESGE and ASGE recommendations) and its use is being explored for polyps 10-20 mm. Recurrence rate of cold snare polypectomy (without submucosal injection) compared to conventional EMR (generally used for polyps >10 mm) for different polyp size is a broader question and is an area of future research. Thank you.

7. Line 136 “The risk of residual or recurrent adenoma (RRA) on follow up at the site of prior initial resection also increases as the lesion size increases” and line 148: “Due to their size, larger polyps especially LSTs are at risk for residual or recurrent adenoma”

Is this just due to the size of the lesion or because the lesion size more often leads to a piecemeal resection?

Reply 7: Thank you. Agree. As the lesion size increases, the risk of transformation for underlying dysplasia to cancer increases. At the same time, larger the lesion, the risk for en bloc resection decreases verily due to its size that limits ability to remove it safely.

Minor:

1. Abbreviation:

Please correct CS-EMR to Endoscopic Mucosal Resection.

Please Correct CSPEB to Clinically Significant Post-EMR Bleeding.

2. Line 95: Please write "Forming" with lower case letter.

3. Line 137: Please specify "advanced adenoma".

4. Line 205: Please further specify the consequences of the piecemeal resection.

5. Line 207: Please add "recurrence" rates.

6. Line 213: Please add the percent sign to the number.

Changes to text: 1-6 all addressed, and text was updated.

In general, I miss a more specific recommendation in this review as to when and which type of endoscopic resection should be used and what limitations the individual resection techniques have.