Peer Review File

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Reviewer A

Very interesting idea and contribution from this article.

In order to state this procedure is safe and effective, however, the following must be addressed:

Comment 1: Typically 30-day complication rates need to be stated (both mortality and morbidity) even if mortality is 0.

Reply 1: Thank you for the feedback. We have added the information on mortality rate (Page 7, Lines 212-213) and morbidity rate (Page 7, Lines 207-208 | Abstract). Morbidity rate has been discussed more clearly regarding complications, site infection, tube dislodgement, and gastrointestinal bleeding.

Changes in the text: "Morbidities (rates) related to…gastrointestinal bleeding (18%)." "The 30-day mortality rate after the procedure was 9%."

Comment 2: Like other papers on proximal decompression (gastrostomy or otherwise) removal of NG tube often considered the goal of the procedure. However, emphasis on this outcome measure understates the impact of vomiting around the tube and the persistence of abdominal pain- which your data also shows. While that is often the nature of the problem, I think it's important to clearly acknowledge that just getting tube out is not the only measure of quality of life or success. Without it claims of effectiveness risk coming across as disingenuous. It's not a bad thing that you have an alternative way to get a NG tube out; I would be careful not to imply that getting tube out is sole governor of effectiveness.

Reply 2: Thank you for your suggestion. We have added a sentence to mention this caveat of vomiting around the tube and persistence of abdominal pain with nasogastric tubes as major issues (Page 8, Lines 238-243)

Changes in the text: "CEG tubes are placed below…CEG tube is an option…"

Comment 3: Patients in this report are highly selected and this must be clearly stated with some acknowledgement of how they were selected vs those that were not.

Reply 3: Thank you. We have added relevant details about patient selection (Pages 8-9, Lines 243-247).

Changes in the text: "At our institution, patients are carefully selected to undergo CEG tube placement on the basis of being palliated by NG tube decompression. Potential candidates are…"

Reviewer B

Authors report a retrospective series of patients who received esophageal decompression for MBO.

Comment 1: The number of patients is limited (two patients per year..) As authors are anonymous, we do not know if patients had a palliative care assessment and treatment. Also the choice to use an interventional procedure over medical management should be explained. This procedure is an alternative to gastrostomy, but no discussion about the possible pharmacological options for MBO are reported. This point should be analyzed and properly discussed

Reply 1: Thank you for your feedback. We have added the palliative care team, who was involved in the decision-making process to determine which patients received a CEG tube (Page 6, Line 181). With regards to medical management, we have already included information explaining the types of and drawback with pharmacological treatment options for MSBO (Page 5, Lines 157-160).

Changes in the text: "…palliative care teams,…"

Comment 2: I would change this sentence: "Peritoneal carcinomatosis, notably of the stomach, gallbladder, colon, uterus, and ovaries, can lead to malignant small bowel obstruction (MSBO) and abdominal distension due to ascites." to "primary tumors, notably of the stomach, gallbladder, colon, uterus, and ovaries, can lead to malignant small bowel obstruction (MSBO), due to peritoneal carcinomatosis"

Reply 2: Thank you for the suggestion. We have changed this sentence (Page 5, Lines 148-149).

Changes in the text: "Primary tumors,…,due to peritoneal carcinomatosis."

Comment 3: This sentence is repeated in Results: had colorectal cancer (36%), with 115 ovarian cancer being the next most common cancer type (27%).

Reply 3: Thank you for alerting us. We have modified the sentence to be less repetitive (Page 7, Line 206)

Changes in the text: "The majority of patients who received CEG tubes had colorectal cancer (36%) or ovarian cancer (27%)."

Comment 4: Pain scores were collected for seven patients before and after CEG tube placement, with six of the seven patients reporting no pain within 4 days after placement, Do you mean "postoperative pain"?

Reply 4: Both pre-operative and post-operative pain were reported as noted in the phrase "…before and after CEG tube placement…" (Page 9, Line 253). Thanks for asking us to clarify.

Changes in the text: None

Comment 5: I suggest to add details and description of the procedure, particularly on burden of that (anesthetics and so on)

Reply 5: Thank you for the suggestion. We have added more details regarding this in the methods section (Page 6, Lines 183-193). The patients required rapid sequence intubation given the risks of aspiration from the bowel obstruction regardless of the presence of a nasogastric tube. Paralytics were not required during the procedure in most cases. A full description was added to the methods

Changes in the text: "Patients underwent rapid sequence intubation…sutured to skin."

Reviewer C

CEG tube is admittedly effective for cancer patients with bowel obstruction of any cause, and may be an effective tool for palliation of symptoms in future cancer patients. However, I have a couple of concerns.

Comment 1: What is the actual level of patient satisfaction? Do you have any data to support this?

Reply 1: Thanks for your question. It appears that patients were satisfied with CEG tube placement. We have quantitative data on pain scores that support this conclusion (Page 9, Lines 253-255). Through informal subjective interviews with patients after CEG tube placement, it was determined that "no patients in this study regretted their decision to receive a CEG tube." (Page 9, Lines 258-260).

Changes in the text: None

Comment 2: You mentioned that abdominal pain is the most common cause of readmission. Is it recurrent bowel obstruction? Is there any tube obstruction?

Reply 2: Thank you for asking this question. We were unable to pinpoint a specific cause for the abdominal pain in readmitted patients because the cause of this pain was often multifactorial. Tube obstruction can be readily treated with piston syringe and was not cause for readmission.

Changes in the text: None

Comment 3: Do ineffective cases have a poor prognosis?

Reply 3: From our data, CEG tubes appear effective for patients with terminal MSBO. The CEG tubes were least effective in the patient with uterine cancer and the patient with gallbladder cancer. However, this result was likely due to the multiple other comorbidities in

both the patients as shown in Table 1. Notably, our selection criteria includes successful decompression with nasogastric tubes and therefore ineffective decompression was not immediately identified following placement of the CEG tubes.

Changes in the text: None

Comment 4: Is the procedure effective in prolonging life?

Reply 4: Based on the efficacy data, the patients had an average survival time of approximately 138 days (Page 8, Line 222) after the procedure. Several patients were able restart chemotherapy after CEG tube placement which we believe has prolonged survival. In order to fully answer this question, a randomized trial comparing patients who meet our selection criteria who receive or do not receive a CEG tube would be necessary. Unfortunately, the frequency of which CEG tube placement is low and therefore it would not be feasible to do this study.

Changes in the text: None

Comment 5: Please sort out the duplicated data in Figures 1-3 and Table.

Reply 5: Thank you for your feedback. We have removed the duplicated data in the revised manuscript (Table 3).

Changes in the text: "Data indicating the efficacy…Figure 2 and Figure 3."