

Peer Review File

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Reviewer A

This paper compared the efficacy of BTS SEMS placement for malignant large-bowel obstruction with that of transanal decompression tube using meta-analysis. The central argument is interesting, however, similar reports have been published in the past and there is no novelty in the content. Analysis from a new perspective is needed. I hope that my comments will prove useful in improving the manuscript.

Comment 1: The discussion is too long. Numerous results from other studies are listed. Please make it shorter. A discussion about the probable reasons for the results and their clinical applications is needed.

Reply: Thanks for your good comments. According to your suggestion, we have revised the Discussion Part in the revised manuscript. Please see that.

Page 4 line 79

Comment 2: The ESGE guidelines were updated in 2020, and now BTS is recommended. Please change the Introduction regarding the ESGE guidelines.

Reply: Thanks for your good comments. According to your suggestion, we have updated the ESGE guidelines in the revised manuscript (page 5 line 7).

Changes in the text: In 2020, SEMS has been recommended by the European Society of Gastrointestinal Endoscopy (ESGE) guidelines as bridge to surgery for MLBO.

Page 11 line 222-230

Comment 3: This part should be described in the Introduction.

Reply: Thanks for your good comments. According to your suggestion, we have placed this part into the Introduction part (see page 5 line 81-87).

Page 11 line 231

Comment 4: A typo “TDTD” is present. “TDT” is the correct abbreviation.

Reply: Thanks for your good comments. Accordingly, we have changed “TDTD” with “TDT” in the revised manuscript (see page 11 line 226).

Page 11 line 239-244

Comment 5: Effectiveness in terms of technical success is mentioned only. Please discuss the clinical success rate as well.

Reply: Thanks for your good comments. Accordingly, we have added the following sentences that discussed the reasons for clinical success rate of SEMS in the revised manuscript (see page 12 line 233-238).

Changes in the text: Previous study has reported that SEMS has a significantly higher clinical success rate than TDT, which might be due to its relatively larger internal diameter. Kawachi J, et al. found that although the tumor size in TDT group was smaller than that in SEMS group, the clinical success rate for TDT was lower than SEMS (41.7% VS 89.4%), which might be the result of the endoscopists’ skill.

Page 12 line 245

Comment 6: Please discuss the reasons for the prolonged operation time.

Reply: Thanks for your good comments. Among the included studies, only three studies reported the data of operation time. Of them, two found that the operative time in SEMS group was significantly longer than that in TDT group; whereas the remaining one showed that the operation time was similar between the two groups. By pooling these data, our result suggested that the operation time was prolonged in the SEMS group. However, none of the included studies had a detailed description on the operation time, we could not give a reasonable explanation for this result.

Page 13 line 267

Comment 7: A typo “peroration” is present. I think the authors meant “perforation” instead.

Reply: Thanks for your good comments. Accordingly, we have replaced “peroration” with “perforation”. Please see page 13 line 265.

Reviewer B

Comment 1: Congratulations, this is a meta-analysis that takes a lot of effort for the one doing it. But that, at the European level, I don't know if it seems to contribute anything new. I find that there is a lack of comparison results of local recurrence and

survival that would give more meaning to the work. Or at least a justification that an attempt was made to search and no data was found about it.

Reply: Thanks for your insightful comments. We agree with you that data about survival-related outcomes, including overall survival, progression free survival, and local recurrence, are important and valuable information for physicians and patients. However, none of the included studies reported these data. Thus, we are unable to analyze these results. We have added this limitation in the Discussion Part. Please see page 14 line 282-286.

Comment 2: The operative data: surgical time, blood loss, complications ... are not only influenced by being a carrier or not of a Stent or TDT but also by the type of patients, tumor stage, surgical team, ... I think they are the result which may be due to other factors.

Reply: Thanks for your insightful comments. We totally agree with you that the operative-related data are not influenced by carriers but also by some other factors. However, due to the limited data, we could not perform subgroup analysis or meta-regression analysis to explore whether these data were influenced by these factors. Thus, we have added this limitation in the Discussion Part. Please see page 14 line 282-286.

Comment 3: One detail: the ESGE currently accepts the use of Stents in selected cases of elderly patients with comorbidities.

Reply: Thanks for your insightful comments. We have update the ESGE guidelines in the revised manuscript (see page 5 line 7).

Comment 4: Perhaps insisting more on details of: hospital stay, preoperative preparation, possibility of preparing the patient from home, prehabilitation, optimization, ... can make the work more interesting.

Reply: Thanks for your insightful comments. We admit that the outcomes you mentioned are interesting. Some of them have been presented in this manuscript, whereas some others are not analyzed because of the insufficient data.

Reviewer C

Comment 1: Well done. I did not have lots of experience in Transanal tube and one could imagine it is not a sustainable option of managing MLBO. Do we have any

comparisons on perforation rate and failure rate to insert and the stoma rate? Those questions are more clinically relevant.

Reply: Thanks for your insightful comments. The perforation rate is presented in this manuscript, which suggested that the perforation rate was similar between the SEMS and TDT treatments (RR=0.18, 95%CI: 0.02, 1.39; P=0.099)(Page 11 line 210). Insertion rate of failure was only reported in one of the included studies (ref 25), which showed that SEMS had lower insertion rate of failure than TDT (0.0% VS 8.9%). Due to the limited data, we did not perform meta-analysis for this outcome. Similarly, the stoma rate was also not compared in this study.