Peer Review File
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Reviewer A

1. The article has heavily concentrated on treatment modalities and only a small proportion has concentrated on the title of this article which is long term care. There needs to be more on the existing literature looking at long term care. This is limited however, the studies published must be mentioned to address the title of this review article.
   Response: Thank you for the comment. We have revised the manuscript to take out the descriptive details of the techniques and focused our attention on the complications (immediate and delayed), follow-up and surveillance, recurrence and management. Revisions are highlighted in red.

2. More is required on long term complications - particularly structuring rates and evidence out there for this. Also the need for EMR/ESD on follow up OGD/scheduled HALO (RFA) sessions must be addressed to see how many patients do progress to dysplastic/malignant nodules following HALO.
   Response: Thank you. We have detailed the complication – rates and management options in the complication section (*Page 3, Line 24- Page 5, Line 5*) as well as in Table 1.

3. The article needs restructuring and to be more focused on the topic intended.
   Response: Thank you for this comment. We have restructured the manuscript. Long term care in our opinion would include follow-up, surveillance, medical management and recurrence and its management, complications and its management. We have also added novel techniques under current evaluation. We hope this current structure is more acceptable. Revisions are highlighted in red.

Reviewer B

1. Please comment about Novel biomarkers are needed to detect high-risk BE patients with low-grade dysplasia who may eventually develop a progression to EAC.
   Response: Thank you for mentioning this. We have added a section in the manuscript titled “Novel techniques and modalities” (*Page 7, Line 27-Page 8, Line-12*).

2. Author says that antisecretory medications for adequate control of acid reflux and also very important to prevent the impact of acid reflux on to resected or ablated mucosa.
   Dongfeng Sun also made two surgical models of gastroesophageal reflux and rats treated with BAs, they demonstrated that BAs in reflux is sufficient to induce esophagitis and Barrett’s-like metaplasia in the esophagus. However, gastric acid alone is not as effective in introducing BE as BAs.
   Immunostaining and gene expression provided evidence that our rat models closely resemble characteristics of BE. They conclude that Barrett’s-like metaplasia partly results from BA reflux. (Bile acids but not acidic induce Barrett’s esophagus Int J Clin Exp Pathol 2015 Donfeng Sun). Masaoka and Donfeng Sun say Bile plays an important role in the expression of BARRETT esophagus. In suppressing the expression of BE. I think it is important to suppress bile, but how about it?
   Response: Thank you for this comment. We have added a paragraph “GERD and bile acid reflux” to the manuscript (*Page 6, Line 25-Page 7, Line 5*)

Reviewer C

The issue is what I am observing is that a) there is no clear causality between the review and factual recommendations, or even a clear study plan. So there is nothing much this review brings to the table

- as there is no systematic analysis or review. So doing a rewrite to highlight the goals of the review would be suitable, as this must be thought provocative.
Response: We thank you for taking the time to review this manuscript. The goal of this review is to indeed provide a narrative review of the current literature. There is a paucity of literature and majority of the recommendations are based on expert consensus. This is in fact the premise of the manuscript. Given the paucity of data, it is not possible to perform any systematic review or meta-analyses.

Reviewer D

It is well written and covers the important aspects in an easy to absorb manner.
I have no major criticisms regarding this review but a couple of comments.
The authors suggest the use of a stent in the management of a perforation post procedure. I would suggest in that an otherwise fairly normal esophagus with minor abnormality this is not appropriate and it is extremely unlikely that a stent will hold in such circumstances. Stents are also fraught with risks- and so if this is going to be alluded to probably requires some expansion- but it would be better to probably remove this and state control of any contamination and provision of nutrition (perhaps through an NJ) are the mainstays for recovery.
Response: We thank you for pointing this out. We have modified the importance of contamination control and alternate nutrition route as primary management. While stent management is possibly riskier, it is still recommended in the algorithm of benign perforations like Boerhaave/iatrogenic endoscopic perforations (IEP). We have added the reference to this to help the readers (PMID: 29557070). (*Page 4, Lines 9-12*)

Also the authors have suggested annual surveillance in those that had IMA on an initial biopsy. I think if there have been prolonged negative for dysplasia periods this does not need to be annual and should be spaced our as per discussion at a tumour board?
Response: While this is a reasonable approach, given high rate of IM recurrence post BET/EET, current approach is to continue annual surveillance. We however had modified the discussion to reflect long term surveillance strategy to be based on discussion between the GI provider and the patient explaining utility of ongoing surveillance endoscopies to derive at an informed decision based on understanding of risks and benefits involved and overall health status of the patient in absence of a consensual guideline recommendation and need for high quality data. (Page 6, line 23-28)