Peer Review File

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Reviewer 1:

Comment 1: This review highlights the need for standardization of upper GI endoscopic reporting after fundoplication. It should be emphasized that the operating surgeon should clearly describe the fundoplication and take representative images to serve as a baseline for future comparison

We agree with the Reviewer and have emphasized this on page 12, lines 254-260.

Reviewer 2:

Comment 1: The subject of the study is interesting. However there are some aspects of the study that can be done better. It would be valuable for the reader to learn more about how the description of endoscopic image after anti-reflux surgery should look like – is the Hill scale sufficient enough? Some other important features are enumerated in the Table 3. Maybe it should also appear in the main text. Can the authors propose what the "perfect description" should contain?

The Reviewer makes an important point. We have included the "perfect description" (in our opinion) on page 12, lines 254-260.

Comment 2: What according to authors is the reason of insufficient describing of cardia after anti-reflux surgery? Lack of standards? Ignorance? Lack of information about the surgery in the referral? How often it happens?

It is not for the authors to assume the reasons behind the insufficient description of prior anti-reflux surgery during endoscopy. Part of the reason will certainly be due to a lack of universally accepted reporting standards. In cancer, for example, a standard reporting proforma was introduced in pathology to improve reporting of cancer specimens. We hope our narrative review will shed light on the problem, and perhaps lead to a similar universally accepted proforma for endoscopic reporting of prior anti-reflux surgery.

Comment 3: If there are some studies in raters accordance – what are the achieved kappa values? Are the kappa values for anti-reflux surgery evaluation far different from those achieved in other diseases / conditions?

Upon re-running of the database searches, a recent publication was found which looks at the assessment of fundoplication (published following our initial review of the literature). There was poor inter-rater agreement found in this study although there were only 31 participants. This study has been added to the Results section on page 7, lines 140-145.

Comment 4: There are certainly more articles on inter-rater reliability of upper GI endoscopy findings that can be included into analysis, for example:

- *Justyna Wasielica-Berger, Andrzej Kemona, Joanna Kisluk, Agnieszka Swidnicka-Siergiejko, Pawel Rogalski, Adam Chwiesko, Maja Kostrzewska, Andrzej Dabrowski. The added value of magnifying endoscopy in diagnosing patients with certain gastroesophageal reflux disease Adv Med Sci 2018; 63(2):359-366. doi: 0.1016/ j.advms.2018.04.006.*
- *Rath HC, Timmer A, Kunkel C, Endlicher E, Grossmann J, Hellerbrand C et al. Comparison of interobserver agreement for different scoring systems for reflux esophagitis: Impact of level of experience. Gastrointest Endosc 2004;60:44-9.*

The two articles listed above were not included in our narrative review. We realized, after re-running the database searches with the added search term 'agreement', that we had missed 26 articles. One of these pertained to fundoplication, and the remaining 25 were on interobserver agreement in upper GI endoscopy (and include the two listed above). We are grateful to the Reviewer for highlighting this error, and have now included the additional 26 studies in the narrative review.

Comment 5: Can the word proceduralists in methods section be replaced by endoscopists?

Yes we have corrected this error (p.8, line 169).

Comment 6: "Assessment of gastroesophageal pathologies" term in the Inclusion criteria in the methods section is not precise. Did the authors mean interobserver agreement?

The inclusion criteria has been adjusted and now reads as the assessment of interobserver reliability/agreement (page 5, lines 109-111).

Reviewer 3:

Comment 1: This review article has identified the scarcity of literature on assessment of fundoplication on endoscopy. The underlying reason may be that the incidence of endoscopy after fundoplication is not high as the majority of patients would have symptom improvement after surgery, and there are alternatives to assessment of the efficacy of the fundoplication such as a barium swallow to look for gastro-esophageal reflux or wrap migration. In the real world, the indications for performing endoscopy at variable duration after fundoplication could be for failed fundoplication or other reasons such as anemia, dyspepsia, weight loss, bloatedness, surveillance of Barrett's oesophagus, etc. Therefore the fundoplication might not been of primary interest of endoscopy after fundoplication. Otherwise, it would have been logical to give a more accurate assessment of the fundoplication when endoscopy was performed for problems related to the fundoplication.

The senior author on this paper has worked as a specialist upper GI surgeon for over 15 years. In fact, many patients require ongoing endoscopic assessment following anti-reflux surgery, the most common reason being surveillance of Barrett's oesophagus. The minority are having endoscopy to evaluate recurrent symptoms, and the Reviewer is correct that barium swallow is often a superior investigation in this scenario.

Regardless of the reason for the endoscopy, the authors feel strongly that the presence or not of a fundoplication, and its description, are important to document on the endoscopy report. We have included the "perfect description" (in our opinion) on page 12, lines 254-260.

Comment 2: As the number of relevant publications are small, this review does not add useful information and much so the need to publish the "lack of literature".

The narrative review highlights the nature of the problem, and provides a framework for developing an evidence-based study to formally assess the reliability of fundoplication assessment amongst endoscopists.