Peer Review File
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Reviewer Comments

Reviewer A

Comment 1: Table 1 is duplicated with line numbers, please correct.

Reply 1: We are not sure what the reviewer means by this comment. Are they referring to the reiteration of Table 1 contents in manuscript lines 220-232? We can address this comment if the reviewer/editorial team would kindly provide further clarification. From our perspective, Table 1 appears to be formatted appropriately and conveys the desired parameters.

Comment 2: Table 1; when EVT is performed, all patients are led to the CD IIIb complication group. Otherwise, if another complication occurs in these patients, please raise the diagnosis and numbers.

Reply 2: Not all patients who undergo EVT for Anastomotic leak are considered to have a CDIIIb complication within the data set discussed in this study. CD IIIa refers to *'Complications requiring surgical, endoscopic or radiological intervention not under general anesthetic.'* Referring to Table 1- three patients had all of their EVT procedures performed with sedation and had no further complications warranting general anesthetic so have been coded as having CD IIIa complications. Additionally, four patients had grade IV complications (Table 1). Specific post-operative complications and EVT-related complications are provided with respective frequencies in Table 2.

Comment 3: The Kaplan-Meier curve of EVT success is informative for readers.

Reply 3: We thank the reviewer for this comment. We agree this may be beneficial for readers to ascertain the time to treatment success, as has been discussed in similar EVT publications.

Comment 4: Please provide the contrast examination before and after EVT.

Reply 4: We do not routinely perform contrast swallows or CT with oral contrast post-EVT. We are guided by the patient's clinical progress and inflammatory markers and use periodic CT scans of the thorax (with IV contrast) to assess progress with respect to the size of any mediastinal cavity and collections. Visually the anastomotic leak is assessed endoscopically for confirmation of full epithelialization of the fistulous orifice, at which point the EVT drain may be removed entirely.

Reviewer B

Comment 1: Consider discussion between intraluminal and extraluminal groups; data should be available.

Reply 1: Thank you for this suggestion. This has been evaluated in further detail with the addition of Table 3 which reviews EVT-related outcomes with comparison based on the initial placement of the EVT drain to an intraluminal or intracavitary position. The outcomes of this analysis have been further commented on in the discussion section.

Comment 2: What's the difference between EVT and fenestrated EVT?

Reply 2: This is broadly explained in section 1.2 (pg.6 Lines 90 – 111). EVT typically uses a sponge attached to a drainage tube – this may be a self-made adaptation or a commercially available device. The EVT with drain technique described in the study does not involve a sponge but rather a fenestrated surgical drain. Similar techniques have been reported using an NG tube applied to suction but not specifically a fenestrated surgical drain that is conventionally used as an active drain for wound drainage.

Comment 3: Retrospective in-depth analysis at a tertiary center. Important work, not new, but needed for more validation. The result - and discussion section should be revised, especially the literature

Reply 3: Thank you for your suggestions – several changes have been made to the discussion and results section in the context of reviewer feedback.

Reviewer C

Comment 1: The known high success rate of EVT could be reproduced, which however

was performed as a new approach with a simple fenestrated 18 French silicone drainage, but with an unusually high suction of 200 mmHg. Several questions arise regarding this new concept: It would be desirable if more on the technical design of the system was explained and illustrated. How is the connection to the drainage system made and which pump is used? What is the rationale behind this significantly higher suction?

Reply 1: Thank you for your suggestions. Higher pressures are used as the drain is connected to wall suction as opposed to a portable system (e.g. Thopaz™ Device). The use of wall suction may result in inconsistent pressures, and subsequently use a higher pressure of 200mmHg. We agree that an illustrated diagram of the system would be beneficial to readers. The wall suction device that is used is the (Diamond Suction Unit ®).

Comment 2: How exactly is the drainage positioned? In how many procedures was the drainage placed endocavitally and how many endoluminally? How often was an additional feeding tube placed?

Reply 2: A full description of the method of placing the EVT drain in both an intracavitary or intraluminal position is described (lines 182-194). For clarification in our center, we do not routinely perform feeding jejunostomy with esophagectomy in all patients. Subsequently to facilitate enteral feeding a Nasojejunal Freka® 8Fr feeding tube is placed during endoscopy for investigation of AL immediately before EVT placement in most instances. The frequency of the initial placement site of the EVT drain (intraluminal or extraluminal) is already provided in Table 2. However, we have data with respect to the position of EVT drain for all procedures and this has been added as a new item to Table 2. Some procedures may involve initially an intraluminal placement of EVT drain transition to placement into the cavity if it widens. Conversely, if the drain is placed initially within the cavity, it may be withdrawn into an intraluminal position abutting the cavity whilst awaiting full closure of the cavity.

Comment 3: During the median treatment period of 19 days, the large-lumen drain is in the nose (patient compliance?), and in the intraluminal position, the esophagus is

blocked by the suction. How should the resulting reduction in quality of life be assessed?

Reply 3: Thank you for this comment, it is a fair suggestion with respect to the assessment of quality of life in examining the utility of this EVT with drain approach. We have not performed quality of life assessment or patient discomfort assessment for this technique in this cohort of patients. This warrants addition as a limitation of this study in the discussion section. Patients typically have NJ feeding tubes inserted at the time of the procedure and subsequently receive enteral nutrition. They are still able to sip water <30mls despite EVT in an intraluminal position.

Comment 4: The VACStent has been available for 3 years as a new commercial EVT device. This should be discussed as a novel alternative.

Reply 4: Thank you for this suggestion, this is a fair discussion point; we have expanded on this in both the introduction section and discussion sections

Comment 5: The main limitation of the study is the fact that large, complicated anastomotic insufficiencies (type 3) were not included, which influences the outcome. This should be discussed critically.

Reply 5: Our practice has been to detect anastomotic leak at an early stage through a low threshold to perform CT with IV contrast and diagnostic OGD if any signs of AL are present. As we detect leaks promptly leaks are diagnosed early with a typically smaller fistulous orifice. However, we accept that it is a key limitation that this cohort analysis is predominantly performed on patients with smaller defect depths and diameters than other similar studies and have updated this within the discussion.