Reviewer’s report

Title: Histology and localization of large colonic polyps (>20 mm) and their impact on occurrence of synchronous polyps.

Version: 2 Date: 30 March 2015

Reviewer: Frank Kallenberg

Reviewer’s report:

Dear authors,

We read your manuscript with great interest. It describes the characteristics of large colonic polyps as well as the prevalence and characteristics of synchronous polyps in patients with large colonic polyps. The retrospective results are based on a large cohort of patients that underwent an EMR due to sessile and flat colonic polyps of >20mm in an academic endoscopy unit. Below please find our comments to your manuscript.

Major compulsory revisions:
1. All EMR’s were performed at an academic center. More information is needed about the indication for these procedures; were these patients referred from other centers and if so, for what reason? Does the studied population reflect the general patient with a large colonic adenoma or is selection bias present? If most of the studied patients were referred from other centers, it could result in more proximally located lesions, as they are more difficult to remove resulting in referral to an academic center.

2. The macroscopic aspect of polyps was not taken into account. It is relevant to know if polyps that turned out to be adenocarcinoma, were endoscopically recognized accordingly.

Minor essential revisions:
3. Patients were included from 2003 to 2014; imaging techniques have changed over the last decade, so it is debatable if the quality of colonoscopies performed in 2003 are comparable to those performed in more recent years. You could mention this in your discussion.

4. Page 11, line 5: what is the difference between severe and high-grade dysplasia?

- The title of the manuscript does not seem to reflect the content as the manuscript only describes flat and sessile polyps. We think this should be adjusted accordingly in the title.

5. The authors focus on the grade of dysplasia, but do not take into account if adenomas are tubular, tubulovillous or villous (although it is mentioned in table 1). We think it would be interesting to involve these data too in order to describe results in terms of advanced or non advanced neoplasia.
6. Please describe how the size of polyps was determined.
7. Please describe who performed the endoscopies; trainees or senior gastroenterologists?
8. It is debatable if a post hoc description of polyp morphology is as accurate as a live assessment of morphology. Please mention this in your discussion.
9. Did you exclude patients with polyposis syndromes?
10. I would suggest to separate the discussion into several chapters to make it easier to read.
11. The authors state that their results support the use of endoscopic instead of surgical procedures. This statement is, in our opinion, not relevant, because complication rates of EMRs were not reported or compared to surgical procedures.
12. Table 2: How did you define serrated adenomas? And why is not mentioned whether these showed low grade of high grade dysplasia in this table?
13. Figure 2: please explain why you chose specific cut-off values for this model, such as a size of 35mm in the rectosigmoid and 22mm in other parts of the colon. The benefit of this table is not completely clear to me.

Discretionary Revisions:
14. The term advanced dysplasia is not a commonly used term. Dysplasia is usually divided into low grade and high grade dysplasia.

Minor issues not for publication:
15. There are some linguistic issues that should be adjusted, such as page 5, line 13: ‘part of’ instead of ‘part on of’.

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:
I declare that I have no competing interests