February 25, 2013

Dear Editor,

Please find enclosed the edited manuscript in Word format (file name: 2124-review.doc).

**Title:** Hepatocellular Carcinoma: Clinical Study for Long-Term Survival and Choice of Treatment Modalities

**Author:** Ketong Wu, Cunchuan Wang, Ligong Lu, Weidong Zhang, Fujun Zhang, Feng Shi, Chuanxing Li

**Name of Journal:** *World Journal of Gastroenterology*

**ESPS Manuscript NO:** 2124

The manuscript has been improved according to the suggestions of reviewers:

1 Format has been updated

2 Revision has been made according to the suggestions of the reviewer

(1)” Inclusion and exclusion criteria of HCC patients should be clearly described.”

**Response:**

The inclusion and exclusion criteria of HCC patients has been clearly described in the text on Page 6.

Study eligibility criteria were as follows: (a) HCC diagnosis confirmed; (b) Only surgical resection, TACE or RF (or MWA) were performed or their combination; (c) The surgical resection was performed using a target resection margin of at least 2 cm. (d) Karnofsky performance scale score of 70% or great­er; (e) Child-Pugh class A or B cirrhosis; (f) No ascites detected; (g) No active infection; (h) no previous treatment for HCC.

Study exclusion criteria were as follows: (a) the treatment data were incomplete; (b) HCV-positive status or alcoholic liver disease (c) partially liver resection; (d) patients with Child-Pugh status C disease; (e) patients with advanced cardiac or pulmonary diseases, (f) patients with evidence of extrahepatic spread of disease; (e) receiving other treatment except surgical resection, TACE or RF (or MWA).

(2) “Differences in therapeutic methods are shown to be significant predictors of long-term survival. Therefore, the therapeutic selection policy for HCC should be clearly described. Please mention the therapeutic selection criteria for surgery and transarterial chemoembolization (TACE) therapy, and include the embolic agents used in TACE therapy”

**Response:**

***Surgical resection:*** Surgery was performed with patients under general anesthesia using a right subcostal incision with a midline extension. Intraoperative ultrasound was used to assist. Anatomic resection was performed using a target resection margin of at least 1 cm.

***TACE:*** Patients were given a standard drug regimen of emulsified Doxorubicin (40–60 mg), Lobaplatin (20–60 mg), and lipiodol (5–40 ml) through the hepatic artery.

(3) “Were there significant differences in survival rates between the 5-year and 10-year survival groups based on individual etiologies, including HCV-positive status and alcoholic liver disease?”

**Response:**

The individual etiologies, HCV-positive status and alcoholic liver disease are not the inclusion criteria of our study, therefore, we have not analyse the survival rates between the 5-year and 10-year survival groups based on individual etiologies, including HCV-positive status and alcoholic liver disease.

(4)” Some recent reports have suggested that the therapeutic results of RFA are better than those of TACE, at least in patients with HCC of 3 cm or smaller. Therefore, the reasons for not using RFA as the first treatment should be explained. In addition, RFA with CT guidance was performed for patients with recurrent or residual HCC, but RFA guided by ultrasonography (US) is relatively simple and gives correct results in many cases, without exposure to radiation. It is unclear why US was not used in the initial HCC treatment in the study. ”

**Response:**

Although RFA guided by ultrasonography (US) is relatively simple and gives correct results in many cases, without exposure to radiation, it has its own defect such as its low definition and distinguishability than CT, besides, ultrasonography (US) is easily affected by gas in the enterocoelia and rib, therefore, ultrasonography (US) guided treatment was not usually as the initial choice.

(5) “Please give the full names of “THP” and “DDP” rather than using abbreviations.”

**Response:**

“THP”- Doxorubicin and “DDP” – Lobaplatin, this has been revised in the whole text.

(6) “In Table 3, p-values are not shown for ‘Time interval …. in the first occurrence’ for the 5-year survival group.”

**Response:**

The p-values in the Table 3 has been added accordingly.

The p-value 0.012

3 References and typesetting were corrected

Thank you again for publishing our manuscript in the *World Journal of Gastroenterology.*

Sincerely yours,

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Chuanxing Li; MD

Cancer Center and State Key Laboratory of Oncology in South China,

Sun Yat-sen University,

Guangzhou, P.R. China;

Tel: 86-20-87343272 ; Fax: 86-20-87343272

Email: lichuanh@mail.sysu.edu.cn