

## COMMENTS TO REVIEWER

Kim and colleagues present a well-written, comprehensive and interesting review on post-surgery chylous ascites in urology. Since I am not a urologist, I can not judge the contents of the review concerning specific issues of urology. Concerning chylous ascites in general, a few points need clarification:

→ Thank you for your kind and detail review, following your review, we revised our manuscript.

- section "etiology and incidence": the different causes of chylous ascites should be given in more detail. In particular, it should be noted that the differential diagnosis is very broad after excluding congenital causes, (surgical) trauma or malignancy. Peritoneal infections causing chylous ascites are rare, but often particular infections. Cirrhosis is another common cause that should be mentioned. If malignancy or (surgical) trauma are the most frequent cause, depends on the fact if a surgical or non-surgical cohort of patients is studied.

→ We added more different causes of chylous ascites in detail in the 1st paragraph of 'etiology and incidence' section.

- section diagnosis: it should be mentioned that chylous ascites is defined by the presence of chylomicrons, which are however difficult to measure, so that triglycerides are usually taken as surrogate parameters. The milky aspect may be misleading if the patient is fasting (in the absence of fat absorption, no triglycerides are transported) or if the ascites is chylous and bloody, which may resemble pus. Sterility is not necessary for the diagnosis of chylous ascites, which may become superinfected. Imaging techniques may indicate the cause of chylous ascites, but are not adequate to diagnose chylous ascites.

→ Following your suggestion, we added those comments in the diagnosis section.

These points should be clarified.- to my knowledge, there is no clear evidence that repeated paracentesis confers a substantial risk for iatrogenic infection. If performed right, risk of infection by the procedure itself is very low unless a permanent percutaneous tube is placed. section

→ We agree with your opinion that if properly performed, repeated paracentesis may not increase the risk of peritoneal infections. However, it is true that there is anyhow possibility of peritoneal infection after repeated paracentesis, and not a few references indicated the possibility of peritoneal infection after repeated paracentesis (Leibovitch et al. The diagnosis and management of



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postoperative chylous ascites. J Urol 2002;167:449, Baniel et al. Management of chylous ascites after retroperitoneal lymph node dissection for testicular cancer J Urol 1993;150:1422). So, we just expressed that there are some "concerns" of the risk of infection after repeated paracentesis in the 3rd paragraph of 'Management' section.

"prognosis": the statement on success rates of treatment, claiming that studies with 2 or less cases may indicate a high rate of treatment failure due to low numbers, is quite complicated. Perhaps it may be easier to calculate the total success rate for the published cases in table 1.

→ Following your suggestion, we calculated the total success rate for the published cases and described in the 'prognosis' section.

In this table, the success rate for He et al. is given wrongly: instead of 1/1 it must be 0/1.

→ We corrected it.

section "conclusion": the conclusion that chylous ascites is a "highly morbid" complication seems exaggerated.

→ We revised that sentence as "it can become a highly morbid complication..."

- in general: the authors refer several times that chylous ascites may lead to malnutrition and infections. However, they should explain the pathophysiology: chyle is rich in fat, lymphocytes and immunoglobulins, therefore loss of chyle means a loss of nutritional energy and immunocompetence. Thank you for the comprehensive and good review.

→ Following your suggestion, we added that comment in the 2nd paragraph of 'introduction' section.