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Center for Advanced Laparoscopic,
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Dr. Ze-Mao Gong
Scientific Editor
WORLD JOURNAL OF GASTROENTEROLOGY

RE:
Manuscript No.: 29835
Column: Retrospective Cohort Study
Title: DYSPHAGIA AFTER VERTICAL SLEEVE GASTRECTOMY: EVALUATION OF RISK FACTORS AND ASSESSMENT OF ENDOSCOPIC INTERVENTION

Dear Dr. Gong:

We appreciate the opportunity to improve our manuscript using the comments and suggestions provided by the editorial office and the external reviewers. Our changes in this revised manuscript have all been underlined in the word file marked as "WithCorrections". We have attached a revised manuscript with no corrections noted in a word file marked as "cleancopy".

As requested, we have updated the manuscript according to the Guidelines and Requirements for Manuscript Revision-Retrospective Cohort Study. We do not have access to CrossCheck. The revised manuscript was therefore checked by "grammarly", and no plagiarism was detected; we have attached a copy of the screen from this check. The final title was searched by Google Scholar; there was no overlap detected and we have attached a copy of the screen from this check.

We appreciate the review by Reviewer 1. In addressing the comments of Reviewer 1:

Reviewer 1 requests that we check for grammatical errors. We have checked for errors using Microsoft Word and grammarly after revising the manuscript to convert our new information into only present tense and previously published information into only past tense.

As pointed out by Reviewer 1, we have now provided at the end of the Discussion a summary of limitations of this study related to it being a retrospective study rather than a prospective study.

Reviewer 1 inquires as to the origin of modifiable risk factors. We have submitted to another journal a description of the prevalence of preoperative clinical thiamine deficiency in medically-complicated individuals with obesity considering bariatric surgery. In an additional study, we

hope to determine whether individuals with preoperative thiamine deficiency develop postoperative complications of thiamine deficiency, which therefore may be preventable.

As requested by Reviewer 1, we removed Dr. Tran from the statistics description.

As requested by Reviewer 1, we have added references to statements that we make in the revised manuscript.

As requested by Reviewer 1, in the revised abstract, we list the 3 aims and/or objectives of this study and we summarize the results from our study of the 3 aims.

As requested by Reviewer 1, we have revised the wording to indicate that the analysis examines associations and that we are not directly detecting causation.

As requested by Reviewer 1, we have revised the Methods section to provide a clear definition of stenosis of the gastric sleeve.

As requested by Reviewer 1, we now provide all SDs for continuous variables and % for categorical variables.

However, we did not include a description of a manuscript describing endoscopic dilation of the pylorus after sleeve gastrectomy. We have not specifically quantified our endoscopic findings but we and other individuals in this area routinely see a patulous pylorus after sleeve gastrectomy and no one in this study underwent dilation of the pylorus.

We also appreciate the review by Reviewer 2. In addressing the comments of Reviewer 2:

1) What about technical reasons for this complication? We are presently preparing a prospective endoscopic study for Human Studies Subcommittee review to examine specific findings at preoperative endoscopy that might be helpful in understanding the postoperative configuration of the gastric sleeve. The revised manuscript provides a more detailed description of the standardized performance of our 3 bariatric surgeons during the period 2013 to 2015 used for this present study.

2) What about preoperative gastroesophageal reflux disease and dysphagia? We agree that this is an important question. This would in our opinion require a prospective study involving both preoperative upper endoscopy and well as preoperative 24 hour pH and impedance monitoring. We have attempted to summarize the present findings in this field of GERD research in our revised Discussion.

We also appreciate the review by Reviewer 3. In addressing the comments of Reviewer 3:

1) Reviewer 3 inquires about mixing two etiologies of dysphagia into one manuscript. In the revised Discussion, we have added the limitations of a retrospective study. An attempt to delineate the medical risk factors from surgical risk factors would, we believe, require development of a prospective study, which we are now trying to develop.
2) Reviewer 3 inquires about why we chose 2 weeks for initiation of studies of dysphagia. As described in the revised Methods section, the 2 week period came from a summary of advancement from a liquid diet to mechanical soft diet in national recommendations. We did not use a 6 to 8 week period in this study because of surgeons did not feel comfortable having patients with solid food dysphagia waiting for 6 to 8 weeks postoperatively prior to evaluation.
3) Reviewer 3 asks as we have done to correct the number of included patients in the abstract.
4) Reviewer 3 inquires about providing a complete description of both our endoscopic and medical findings in the abstract. In the revised Abstract and Results section, we list the 3 aims and/or objectives of this study and we summarize the results from our study of the 3 aims. This retrospective study was not designed to attempt to determine whether medical therapy of modifiable medical risk factors leads to resolution of dysphagia. We believe that a future prospective study will be required to properly address this important question.
5) Reviewer 3 inquires about evaluation of patients at 6 to 8 weeks after surgery. We did not use a 6 to 8 week period in this study because of surgeons did not feel comfortable having patients with solid food dysphagia waiting for 6 to 8 weeks postoperatively prior to evaluation. As described in the revised Methods section, the 2 week period came from a summary of advancement from a liquid diet to mechanical soft diet in national recommendations.
6) Reviewer 3 inquires about the outcome of the 22 patients with dysphagia who underwent upper endoscopy and did not have a structural cause for dysphagia. As described in the revised manuscript, all patients with dysphagia were offered upper endoscopy. Patients who had no structural cause for dysphagia were maintained on medical management which generally would be a liquid diet and use of an oral proton pump inhibitor. Any identified treatable medical condition was discussed with the patient and appropriate treatment was offered. This retrospective study was not designed to attempt to determine whether medical therapy of modifiable medical risk factors leads to resolution of dysphagia. We believe that a future prospective study will be required to properly address this important question.
7) Reviewer 3 inquires about the 25 patients who declined upper endoscopy. Patients who declined upper endoscopy were maintained on medical management which generally would be a liquid diet and use of an oral proton pump inhibitor. Any identified treatable medical condition was discussed with the patient and appropriate treatment was offered. We did not perform radiological procedures on these patients because it does not allow therapeutic intervention. Our apparent prevalence of gastric stenosis may have been higher if we have had improved patient compliance with regards to undergoing upper endoscopy.
8) Reviewer 3 inquires about the risks factors for dysphagia in patients who did not have a structural cause for dysphagia identified at upper endoscopy (either no endoscopy

was accepted by the patient or no structural problem was identified at endoscopy). This study was designed to use a multivariate statistical analysis to examined medical factors that we thought could be risks for the development of dysphagia after vertical sleeve gastrectomy. Since it is a retrospective study, our revised Discussion summarizes the weakness of a retrospective study in examining all potential factors.

9) Reviewer 3 inquires about the uniformity of the surgical procedure. In the revised Methods section, the uniformity of the surgical procedure used by our 3 bariatric surgeons is summarized. The type of stapler used is described in the revised manuscript in the Methods section and no other stapler was used. Repair of a significant hiatal hernia is not an exclusion in this study and repair at vertical sleeve gastrectomy is very rare in our patient population. The revised Methods section now states that staple line reinforcement was routinely used for all surgical procedures.
10) Reviewer 3 inquires about whether our surgeons changed the size of the bougie that they standardly used during vertical sleeve gastrectomy in the study period. Our bariatric surgeons did not change the size of the bougie that they used during the study period of 2013 to 2015.
11) Reviewer 3 asks an important question about the relationship in the literature between bougie size and dysphagia. This important question we believe will require a separate review article, following the completion of an extensive examination of reports in the world literature about the prevalence of dysphagia with regards to bougie size after vertical sleeve gastrectomy.
12) Reviewer 3 asks whether we can break down the dysphagia group. We are sorry but we do not understand what the question is asking about.

We also appreciate the review by Reviewer 4. In addressing the comments of Reviewer 4:

1) Why are 352 patients included? The revised manuscript summarizes the exclusion criteria for this study which excluded 48 patients.
2) We did not use a scoring system for dysphagia.
3) As described in the revised manuscript, all patients with dysphagia were offered upper endoscopy; 55 patients agreed to upper endoscopy; patients who declined upper endoscopy were maintained on medical management which generally would be a liquid diet and use of an oral proton pump inhibitor. Any identified treatable medical condition was discussed with the patient and appropriate treatment was offered.
4) The revised Methods section now states that staple line reinforcement was routinely used for all surgical procedures.
5) Patients were not studied by radiology postoperatively, and so we have no information about radiologic appearance in patients with dysphagia.
6) The revised Methods section now summarizes the standard mulvitamin supplementation that we recommend to all preoperative and postoperative patients. As a side bar, we have already published data twice (Nutrition Research 2008 and Digestion 2013) supporting the concern that oral supplements of thiamine may not be beneficial.
7) In the revised manuscript, we limit the number of significant figures.

8) Patients not aided by either endoscopic dilatation or medical therapies have been seen by our bariatric surgeons to discuss potential revisional surgery.
9) We have as suggested shortened the discussion from 6 pages to a little over 4 pages.

Thank you for considering our revised manuscript for potential publication in the WORLD JOURNAL OF GASTROENTEROLOGY.

Very truly yours,

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