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PEER-REVIEW REPORT

Name of journal: World Journal of Radiology
Manuscript NO: 32701
Title: Imaging of the Treated Breast Post Breast Conservation Surgery/ Oncoplasty: A Pictorial Review
Reviewer's code: 00504611
Reviewer's country: United Kingdom
Science editor: Xiu-Xia Song
Date sent for review: 2017-03-09
Date reviewed: 2017-03-10

CLASSIFICATION	LANGUAGE EVALUATION	SCIENTIFIC MISCONDUCT	CONCLUSION
[ ] Grade A: Excellent [Y] Grade B: Very good [ ] Grade C: Good [ ] Grade D: Fair [ ] Grade E: Poor	[Y] Grade A: Priority publishing [ ] Grade B: Minor language polishing [ ] Grade C: A great deal of language polishing [ ] Grade D: Rejected	Google Search: [ ] The same title [ ] Duplicate publication [ ] Plagiarism [ ] No BPG Search: [ ] The same title [ ] Duplicate publication [ ] Plagiarism [ ] No	[ ] Accept [Y] High priority for publication [ ] Rejection [ ] Minor revision [ ] Major revision

COMMENTS TO AUTHORS

This is a useful and valuable short review on this topic. The review is concise and well written. Typos: Page 4: "at or within a few centimetres" rather than "at or within few centimetres"

All comments have been addressed.

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[ ] Grade D: Fair	[ ] Grade D: Rejected	[ ] Plagiarism	[ ] Minor revision
[Y] Grade E: Poor		[ ] No	[ ] Major revision
		BPG Search:	
		[ ] The same title	
		[ ] Duplicate publication	
		[ ] Plagiarism	
		[ ] No	

COMMENTS TO AUTHORS

GENERAL COMMENTS This manuscript is well written and the data set has long follow up. However, it can hardly be called a review. It is a collection of images illustrating the different types of appearance of the breast after mastectomy, based almost exclusively on mammography even when there appears to be no place for mammography (Figure 16).

Figure 16 - The mammogram was not done for the nodes rather enlarged nodes were the only abnormality on follow up mammogram after surgery and were the site of recurrence on histopathology. Teaching point is that one must raise a suspicion if abnormally enlarged nodes are seen.

It is basically a primer for the radiology resident on the appearance of the breast after (mainly) lumpectomy. Some (but not all) of the material could be used in a lecture, but

no more than that. No mention is made of oncoplastic surgery after the title.

After oncoplasty, fat necrosis is common at the native tissue – flap junction as is the recurrent mass depicted in figure 11.

No mention is made of residual disease after the abstract.

Has been removed from abstract.

A review should compare different alternatives and their relative values giving levels of evidence for the preferred approach. It should also describe any controversies surrounding the subject, describe how we got to where we are and what the future holds. Many interesting areas are totally neglected, such as how to follow a patient with involved or very close margins, how to follow a patient with BRCA who has had a prophylactic mastectomy, etc.?

At our institute, margin revision is advocated prior to radiotherapy and adjuvant chemotherapy.

SPECIFIC COMMENTS There is not a single image with clips marking the resected breast (directing radiotherapy, especially after tissue rearrangement in oncoplastic surgery)

The clips are inserted if patient is operated at our institute however most patients come to our tertiary care center after initial surgery for further treatment and follow up wherein clips may not be inserted.

There are no photographs of the breasts imaged to show the scars of resection to illuminate the clinical aspects of the case and to compare with the mammographies.

Clinical images are not available. Many patients due to cultural and social reasons in our type of setup are reluctant to give consent for clinical photographs.

The mix of analog and digital images purporting to show the same patient over time can be confusing to the reader.

We shifted to Digital in 2006. Prior to that we had analog Images captured by Digital camera. The images are shown for the purpose of follow up.

The legend for figure 8 calls the follow up mammogram a scan.

Correction has been made.

The sequences shown in figures 9 10 and 11 appear to represent neglect on the part of the radiologists involved and have no place in an educational article such as this.

Its shows the learning curve wherein the importance of developing asymmetries is depicted. Also for socio economic reasons some of our patients do not come for repeat biopsies until frank disease develops, as in these cases.

Figure 11 is particularly difficult to understand in that the purported skin (it is SO easy to biopsy skin!) nodule is not actually shown in the images. Any new skin nodule after prior breast cancer surgery should immediately raise the suspicion of recurrence.

Skin nodule was clinically seen and mammography was done to look for extent of recurrent disease prior to biopsy as well as for academic purposes to document the lesion.

Figure 12 in spite of the authors' claim there is no resemblance between the original calcs and those in the recurrence, and the MRI is of unacceptably poor quality – could be anything.

Dot-and-dash type of casting microcalcifications are seen in both.

Figure 14 Angiosarcoma is a rare phenomenon that mostly presents with skin changes which should alert the physician well before imaging is done. Again, it is so easy to biopsy skin. There is at least as much skin enhancement in the accompanying MRI as there is in the tumor. A photograph of the breast would have been a valuable adjunct to illuminate the radiologic findings.

Entire skin is enhancing due to involvement by disease in addition a nodular focus is seen. Photograph of breast is not available as this was a retrospective study. Again many patients due to cultural and social reasons in our set up refuse to give consent for clinical photograph

Figure 15. Contrary to what the authors wrote ("the relatively high observed rates of Paget's disease following BCT or subcutaneous mastectomy and reconstruction"), the reference cited (number 15) states that Paget's is RARE rather than common. 4 of 183 local failures in 2181 patients. As to how the diagnosis is made, the key is again physical

examination rather than imaging.

Referring to those who present with nipple changes. The statement has been corrected.

Figure 16. Do the authors really use mammography after mastectomy (with or without autologous reconstruction)? Surely the modality of choice for detecting pathological nodes is ultrasound. In any case axillary recurrence is rare under any circumstance, whether axillary clearance is complete or not. And what is that FDG avid structure in the anterior midline?

The entire breast has been reconstructed with a DIEP flap in which case mammography is done at our institute to see if the DIEP flap is involved. Low grade uptake is seen in the head of the clavicle in right anterior paramedian location.

Figure 18. The two mammograms appear to be from different patients: the vascular pattern of the breast in A is completely different from that in B and there are no microcalcifications or skin thickening in A, which are both very obvious in B.

The difference between Figure 18 A and B is due to positioning. B depicts recurrence, while A is without recurrence year before! The USG images are of recurrence on gray scale, and power Doppler which was seen only as skin thickening and asymmetry on mammogram.

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PEER-REVIEW REPORT

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COMMENTS TO AUTHORS

It should be reviewed by and English expert, otherwise it is a very good study

All comments have been addressed.