

POINT-BY-POINT RESPONSE LETTER TO CRITICISMS

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Manuscript Type: SYSTEMATIC REVIEW

Title: Systematic review of giant gastric lipomas reported since 1980 and report of two new cases in a review of 117,110 EGDs

5/3/17

Dr. Ya-Juan Ma
Science Editor,
Baishideng Publishing Group Inc.

Dear Dr. Ma:

Thank you for your careful review and insightful criticisms of this manuscript. The manuscript has been thoroughly revised in accord with the criticisms and suggested revisions, as follows:

EDITOR'S COMMENTS

1. Title.

SHORTENED TO:

Systematic review of giant gastric lipomas reported since 1980 and report of two new cases in a review of 117,110 EGDs

FROM:

Systematic review of giant gastric lipomas reported since 1980 and report of two new illustrative cases presenting with severe UGI bleeding in a review of 117,110 EGDs

2. Correspondence address.

CHANGED TO:

Correspondence to: Mitchell S. Cappell, MD, PhD, Chief, Division of Gastroenterology & Hepatology, MOB #602, William Beaumont Hospital, 3535 W. Thirteen Mile Rd., Royal Oak, MI 48073 United States

FROM:

Correspondence to: Mitchell S. Cappell, MD, PhD, Chief, Division of Gastroenterology & Hepatology & Professor of Medicine, MOB #602, William Beaumont Hospital, 3535 W. Thirteen Mile Rd., Royal Oak, MI 48073 United States

3. Abstract

Modified as proposed.

4. Audio Core Tip

Added as required.

5. References

All references cited in text of paper changed to format of: reference numbers in superscript in square brackets.

6. Comments Section

New Comments section added, with all the required subheadings, as follows:

COMMENTS

Background

Gastric lipomas are rare, constituting <1% of all gastric tumors, and giant gastric lipomas (≥ 4 cm) are extremely rare, with this systematic review identifying only 32 cases reported since 1980. Although small gastric lipomas are usually asymptomatic, giant gastric lipomas typically produce major, clinically important, symptoms from GI obstruction, tumor ulcers, or upper gastrointestinal bleeding. Due to its extreme rarity, all prior studies of giant gastric lipomas have comprised single case reports. The individual case reports are scattered among numerous, and sometimes obscure, journals. This work systematically reviews the literature since 1980, to comprehensively report what is known about this disease and to inform clinicians and clinical researchers what is not known or controversial about this disease.

Research frontiers

A systematic review is important to collate all the prior data presented as case reports to establish what is known about the clinical evaluation for this disease. This systematic review demonstrates that the standard clinical evaluation should include: (1) abdominopelvic CT to demonstrate the characteristic CT findings of a giant gastric lipoma of a well-circumscribed, submucosal, and homogeneous mass with attenuation of fat; and (2) EGD to demonstrate the characteristic endoscopic findings of these lesions of yellowish hue, well-demarcated margins, smooth overlying mucosa, and endoscopic cushion, tenting, or naked fat signs.

This systematic review demonstrates that the following tests are nonstandard or generally obsolete tests: (1) upper gastrointestinal series has been superseded by EGD and should only be performed in highly unusual circumstances; and (2) traditional abdominal ultrasound has been

largely superseded by abdominopelvic CT which is a better diagnostic test for this condition, and the traditional abdominal ultrasound should be performed only if the differential diagnosis is broad and not specifically directed at documenting a giant gastric lipoma.

This work systematically reviews several clinically important but controversial topics, including: (1) the role of endoscopic ultrasound: this work shows that conventional mucosal endoscopic biopsies frequently result in a non-diagnostic pathologic diagnosis because giant gastric lipomas are generally submucosal, and therefore endoscopic ultrasound with ultrasound-guided needle biopsies may be necessary if preoperative tissue diagnosis is not obtained by conventional mucosal endoscopic biopsies; and (2) the relative roles of the available therapies: endoscopic mucosal resection, laparoscopic transgastric resection, laparotomy with enucleation, laparotomy with full-thickness wedge resection, and laparotomy with partial gastrectomy and gastric reconstruction.

Innovations and breakthroughs

While several case reports have recently been published on giant gastric lipomas, these case reports generally incorporate limited literature reviews. The present work differs in that it provides a systematic review of the literature. The present work also reports 2 new cases of giant gastric lipomas in a review of 117,110 EGDs performed during 11 years at two large teaching hospitals.

Applications

This work provides the following highly clinically relevant conclusion:

1. Standard evaluation for suspected giant gastric lipomas should include EGD to demonstrate the characteristic endoscopic findings of yellowish hue, well-demarcated margins, smooth overlying mucosa, and endoscopic cushion, tenting, or naked fat signs.
2. At EGD a submucosal mass that is a suspected lipoma should be biopsied, even though the yield of superficial endoscopic biopsies in pathologically diagnosing a gastric lipoma is relatively low. The yield of biopsies at EGD may be increased by using jumbo forceps for the biopsies, or by repeated biopsies at the same site (“well” or biopsy-on-biopsy technique).
3. Abdominopelvic CT is a standard test in the evaluation of suspected giant gastric lipomas to demonstrate the characteristic CT findings of a giant gastric lipoma of a well-circumscribed, submucosal, and homogeneous mass with characteristic attenuation of fat.

4. Upper gastrointestinal (UGI) series is now generally considered an obsolete test for evaluation of suspected giant gastric lipomas and should be replaced by EGD.
5. Conventional abdominal ultrasound is not the preferred test for highly suspected giant gastric lipomas, and should be replaced for this indication by abdominopelvic CT. However, abdominal ultrasound may be a very useful initial imaging test for numerous abdominal conditions in which giant gastric lipoma is in the differential diagnosis.
6. Due to scant data about this rare lesion, and absence of prospective, controlled, therapeutic trials there is no universally accepted standardization of preferred therapies for giant gastric lipomas. Reported therapies include endoscopic mucosal resection, laparoscopic transgastric resection, laparotomy with enucleation, laparotomy with full-thickness wedge resection, and laparotomy with partial gastrectomy and gastric reconstruction. All the reported therapies result in a highly favorable prognosis with no reported mortality among the 32 currently reviewed cases and rare severe morbidity because this tumor is benign, characteristically biologically nonaggressive, and is well-encapsulated that renders it readily amenable to resection. There is recent interest on selecting less invasive techniques for lesion removal, including endoscopic mucosal resection or laparoscopic removal, as opposed to the traditional laparotomy for removal. This systematic review shows that further research is needed on the optimal therapy for giant gastric lipomas, and on individualizing the therapy according to the clinical presentation.

Terminology

The term giant gastric lipomas refers to gastric lipomas ≥ 4 cm in diameter. The distinction of size ≥ 4 cm vs. size < 4 cm is clinically important because gastric lipomas ≥ 4 cm generally produce major clinical symptoms from GI obstruction, tumor ulcers, or upper gastrointestinal bleeding, whereas smaller lesions are usually asymptomatic or produce minor symptoms. Furthermore, lesion size often affects the selected therapeutic modality, with lipomas < 4 cm in diameter often removed endoscopically and lipomas ≥ 4 cm in diameter generally removed surgically.

Peer-review

The authors thank the peer-reviewers #00504545 and #0011771 for their careful review of the manuscript and improvement of the quality of the paper due to their judicious and insightful comments.

7. Case Reports

As suggested, the two Case Reports are relocated from the Appendix to the section entitled, “Illustrative Case Reports”.

8. References

As suggested, the DOI has been added to references #: 8, 9, 14, 16, 25, 36, 42, 44, 46.

As suggested, the PMID has been added to references #: 9, 13, 41, 49.

As suggested, Reference #22 has been revised to include all authors.

REVIEWERS’ CRITICISMS.

1. As per the reviewers’ suggestions the language of the manuscript has been improved.

Authors’ changes

1. Table 1. A key has been added at the end of Table 1 for acronyms.
2. Table 2. A key has been added at the end of Table 2 for acronyms.

Thank you for your interest in this manuscript. Please inform us if any further revisions are necessary, which we will gladly accomplish. THE FIGURES HAVE NOT BEEN RESUBMITTED IN THIS REVISED MANUSCRIPT BECAUSE THEY ARE UNCHANGED.

Warm regards,

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