

December 18, 2017

Dear Editor,

Please find enclosed the edited manuscript in Word format (file name: 37038-Revised-Manuscript-revision.docx).

Title: Placement of metal stents for refractory pancreatic duct stricture in children

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Name of Journal: World Journal of Gastroenterology

ESPS Manuscript NO: 37038

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

Reviewer's code 00058446

Thank you for your kind questions about my manuscript. I hope my answers and revised manuscript suit you.

Question 1:

How long was the right time of FCSEMSs placed for MPD strictures in pediatric patients with chronic pancreatitis? How to decide?

Answer 1:

In order to determine the right time of FCSEMSs placement, we considered the following criteria: longer than the period for plastic stent placement (2 to 3 months) and short enough to prevent embedding of stent into the tissue or obstruction. A previous study reported of an adult with chronic pancreatitis who had undergone FCSEMS for 6 months (referred to as reference number 16 in the third sentence of "Discussion"), we decided to place FCSEMS for 6 months to ensure the safety of pediatric study. In the MATERIALS AND METHODS section of the manuscript, we thus added the following sentence: "Removal was planned with rat-tooth forceps at

6 months after placement, ~". Based on the reviewer's suggestion, we added a reference to the previous study in order to present the evidence for the period of stay.

Correction 1:

Removal was planned with rat-tooth forceps at 6 months after placement, unless adverse events or episodes of pancreatitis had occurred.

→ On the basis of previous studies on adults^[16], stent removal was planned with rat-tooth forceps at 6 months after placement, unless adverse events or episodes of pancreatitis had occurred.

Question 2: How to make sure the benign main pancreatic duct (MPD) strictures with chronic pancreatitis (CP) in pediatric patients

Answer 2: In this study, we analyzed only the patients with chronic pancreatitis who did not have evidence of malignancy on ultrasonography, computed tomography, or magnetic resonance cholangiopancreatography. The patients included in this study were school-aged children and adolescents, and the normal range of pancreatic duct diameter was not more than 0.2 mm different from that of adults. (Ref. Chao HC, Lin SJ, Kong MS, et al. Sonographic Evaluation of the Pancreatic Duct in Normal Children and Children with Pancreatitis. *J Ultrasound Med.* 2000; 19: 757-63 [PMID: 11065264]). Upstream main pancreatic duct (MPD) dilatation is defined as more than 3 mm (Ref. Fukukura Y, Fujiyoshi F, Sasaki M, et al. Pancreatic duct: morphologic evaluation with MR cholangiopancreatography after secretin stimulation. *Radiology* 2002; 222: 674–680 [PMID: 11867784 DOI: 10.1148/radiol.2223010684]); thus, because our study patients were those with dominant stricture with narrowed upstream MPD dilatation of ≥ 6 mm on endoscopic retrograde pancreatography, we defined them as benign MPD strictures with CP. In the manuscript, the last line of the patients section in MATERIALS AND METHODS is referred to as "A dominant stricture was defined when the contrast medium on the ERP film was not washed out and the upstream MPD dilation was ≥ 6 mm in diameter^[15]." To clarify the meaning, we added the following sentence.

Correction 2:

Eight patients with CP and benign dominant MPD stricture refractory to PS placement were enrolled (Table 1). Five of the patients were boys and 3 were girls.

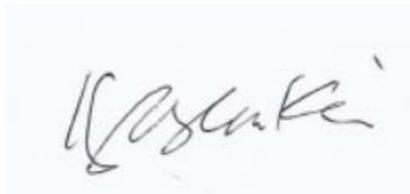
→ Eight patients with CP and benign dominant MPD stricture refractory to PS placement were enrolled (Table 1). Patients with MPD dilatation due to a malignant cause or trauma were excluded. Five of the patients were boys and 3 were girls.

Highlights were added to the manuscript and references were checked that there are no redundancies.

We hope that the reviewer and the editor would now find our manuscript appropriate for publication in *World Journal of Gastroenterology*.

Sincerely yours,

Kyung Mo Kim, MD

A handwritten signature in black ink on a light blue background. The signature is cursive and appears to read 'Kyung Mo Kim'.

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