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World Journal of Gastrointestinal Endoscopy

Subject: Submission of revised manuscript 38734 “Successful Stent-in-Stent Dilatation of the Common Bile Duct Through a Duodenal Prosthesis, a Novel Technique for Malignant Obstruction”

Dear Editor,

Thank you for your email dated 4/25/2018 giving us the opportunity to revise our manuscript based on the reviewer’s comments. We carefully went over the comments and our reply is mentioned below in a point-by-point manner. We have also **highlighted** the responses in the manuscript for your convenience.

Please let me know if I can clarify any other question you may have. I am looking forward to hearing from you soon.

Sincerely,

Gurjiwan Sing Virk MD MSc

Albany Medical Center, NY, USA

Response to the Reviewer

We would like to thank you for this amazing feedback that will help us improve our feedback.

1. Reviewer comment

This paper describes the interventional endoscopic treatment of pancreatic cancer with GOO and bile duct obstruction. The described method is not new and usually performed in a clinical setting, but the description is appropriate for this procedure and valuable for readers. Author mention the final diagnosis of the disease causing the disorders, also in the title.

Reply: Thank you

2. Reviewer comment

- a. GRAMMAR CORRECTIONS ABSTRACT First paragraph - seventh line: change "patient" for "the patient" First paragraph - eighth line: change "decrease" for "a decrease" First paragraph – eighth line: change "post stenting" for "post-stenting" CASE INTRODUCTION First paragraph - fifth line: change "placement" for "the placement" Second paragraph - thirteenth line: change "middle" for "the middle" Second paragraph – fourteenth line: change "were" for "was" DISCUSSION Second paragraph – sixth line: change "though" for "through" Third paragraph – fifth line: change "success" for "a success" Fourth paragraph – second line: change "duodenal" for "a duodenal" Fifth paragraph – first line: change "ultrasound guided" for "ultrasound-guided" Fifth paragraph – sixth line: change "short term" for "short-term" Sixth paragraph – sixth line: change "was" for "were"

- i. **Reply:** Grammar corrections made and **highlighted**

- b. I recommend the authors improve the quality of radiographic images.

- i. **Reply:** -We have added higher quality pictures to help better see the endoscopic and fluoroscopic findings (Figure 1a,1b,1c,1d, 2a,2b, 3a,3b,3c,3d).

3. Reviewer comment

- a. I would suggest the authors to make specific comments about the different type of duodenal stenosis and biliary stenosis, the difficulties to manage each one, improving the discussion and the references. It is very well known the way of managing these types of patients with malignant duodenal stenosis associated firstly, concurrently or latterly with a new malignant biliary stenosis. As the authors pointed out there are some review dealing with this type of the cases. (Hamada T, Moon JH) and other not cited (Baron T Gut and liver , 2010 and so on) .

- i. **Reply:**

1. Added references 6,7
2. Added comments in the 1st paragraph of the discussion. “Usually we can divide patients into any one of the following three categories depending on the chronological order of the obstruction i.e. biliary obstruction before the duodenal obstruction, concurrent biliary and duodenal obstruction or biliary obstruction after duodenal obstruction. In most cases duodenal obstruction happens later during the disease course^{4,6,7}. Further classification can be done based on anatomic location of the duodenal obstruction in relation to the papilla. Gastric outlet obstruction (GOO) type I has duodenal obstruction before the papilla, type II involves the papilla and type III is post papilla. GOO-II is the most difficult to manage via endoscopic stenting whereas GOO-III is the easiest to manage^{4,6,7}.”

- b. The treatment of an initial malignant biliary stenosis which in the evolution developed a malignant duodenal stenosis type II, and treated with a new duodenal stent is the most frequent scenario of biliary and duodenal stenosis to deal with, and the easier one. The more difficult case is the treatment of a malignant biliary stenosis in patients with a duodenal stent and with a naïve papilla. However, due to the patient long survival with a previous biliary stent, the authors’ patient developed a duodenal stenosis type II and a disfunction of the previously placed biliary stent, and the need of two new stenting procedures of duodenum and biliary duct to treat them. At a first sight the physician in charge could think there is no way to try a new endoscopic approach, but the authors showed and taught us that it is possible a new try of biliary stenting, despite the fact of having one previously biliary stent and a new duodenal stent recently placed. The case presented is not so difficult to manage because the access of the CBD is facilitated by the previous biliary stenting, and this is something the authors should comment in the Discussion, and perhaps is the teaching of the case

i. **Reply:**

1. Agree. Added reference 7.
2. Added paragraph on page 6 in discussion “The treatment of initial malignant biliary stenosis resulting in GOO-II that is alleviated with a duodenal SEMS is the most common scenario of biliary and duodenal obstruction intervention. It is easier to stent the duodenal obstruction after stenting the biliary obstruction but not vice versa⁷; however, Moon et al have shown great success in biliary stenting through duodenal stents^{3,5}. In our case, even though the patient had an existent biliary stent, accessing the CBD was difficult due to tumor invasion and bloody debris (figure 3b). There was zero visualization of the papilla making fluoroscopy the only way to

visualize and cannulate the CBD as compared to the naïve papilla (figure 1a) that is seen during the initial CBD stent placement.”

4. Reviewer comment

- a. Although it is a well written paper, the authors present their experience with only one patient. There are other publications (as the authors report) with large number of patients. The allegation that "none of the above studies had patients with both duodenal and CBD stents who required further endoscopic intervention " is not strong enough to justify this presentation.

i. **Reply:**

1. Added references 15 and 16
2. Added paragraph on page 6 in discussion: “There have been previous studies showing plastic biliary stents that were combined with biliary and duodenal metal stenting^{15,16} but to our knowledge, the above studies did not include patients with duodenal SEMS and CBD BMS who required further biliary stenting.”

- b. Probably ERCP in this condition is more challenging in the absence of stent (native papilla).

i. **Reply:**

1. Agreed
2. Commented on page 7 “. In our case, even though the patient had an existent biliary stent, accessing the CBD was difficult due to tumor invasion and bloody debris (figure 3b). There was zero visualization of the papilla making fluoroscopy the only way to visualize and cannulate the CBD as compared to the naïve papilla (figure 1a) that is seen during the initial CBD stent placement.”

- c. A video presentation might be more important.

- i. **Reply:** Agreed but unfortunately, we don't have a video recording. If needed, we can send the procedure PDF with all the images. Although, we have added higher quality pictures for better visualization of the endoscopic and fluoroscopic findings (Figure 1a,1b,1c,1d, 2a,2b, 3a,3b,3c,3d).

Figure 1a Area of the papilla during initial ERCP.

Figure 1b CBD malignant stricture

Figure 1c Cannulating the CBD

Figure 1d Bare metal stent in the CBD

Figure 2a Second portion of the duodenum

Figure 2b SEMS placed in the 2nd portion of the duodenum

Figure 3a CBD and duodenal prosthesis before inserting the CMS into the CBD.

Figure 3b Endoscopic visualization of the papilla site filled with debris and tumor invasion

Figure 3c CMS deployed on the existing BMS in the CBD through the SEMS in the duodenum.

Figure 3d Endoscopic visualization of the CBD stent after the completion of the procedure.

- d. The authors should comment whether the placement of Duodenal stent could have affected the patency of biliary stent.
 - i. **Reply:** Commented on page 6 “The placement of the duodenal stent did not affect the patency of the existing CBD BMS.”

5. Editor comments

- a. RUNNING TITLE
- b. Authors' department
- c. ORCID number
- d. Author contributions
- e. Correspondence to
- f. Show page number
- g. Core tip
- h. Please reformat all the reference numbers with superscript
- i. Format: INTRODUCTION, CASE REPORT, CONCLUSION
- j. Added Article highlights