February 21th, 2019

Dear editor, Jin-Lei Wang

Vice General Manager

The authors are submitting a revised version of the manuscript entitled "**Esophagogastric junction outflow obstruction successfully treated with laparoscopic Heller myotomy and Dor fundoplication: First case report in the literature**". This manuscript is a pioneer report of the association of an anti-reflux procedure combined with the myotomy of gastro-esophageal junction proposing a surgical management of the disease.

We would like to thank both of you and the reviewers for the careful review performed on the manuscript. We have performed all the revisions suggested. The revisions performed are in red color in the point-by-point letter and also in the revised version of the manuscript.

The enclosed manuscript was carefully revised by a Native English speaker. All authors have approved the final version of this manuscript and there are no interest conflicts. The authors believe both the data and the grammar of the enclosed manuscript to be of enough quality to deserve publication in your prestigious journal.

Respectfully yours,

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Associate Editor of World Journal of Gastrointestinal Surgery

(PubMed abbreviation World J Gastrointest Surg)

Reviewer for World Journal of Gastrointestinal Surgery

POINT-BY-POINT LETTER

Supportive Foundations: Financial support was provided by FIPE-HCPA (Research and Events Support Fund at Hospital de Clínicas de Porto Alegre).
We have uploaded the approved grant application form.

CASE PRESENTATION

We performed the suggestion for the case presentation.

1) Chief complaints: A 26-year-old man presented with a 3-year history of solid dysphagia and a 30-kg weight loss. He also complained of heartburn and regurgitation, especially at night.
2) History of present illness: The patient was referred to the outpatient clinic and treated with oral nifedipine, isosorbide, and omeprazole, without resolution of symptoms.
3) History of past illness: was unremarkable.
4) Personal and family history: was negative for gastrointestinal and endocrine disease.
5) Physical examination upon admission: revealed a thin patient. No lumps or abdominal tumors were detected.
6) Laboratory examination: Routine blood tests, routine urine tests and urinary sediment examination, routine fecal tests and occult blood test, blood biochemistry, immune indexes, and infection indexes – all were within normal limits.
7) Imaging examinations: An upper gastrointestinal series (barium swallow) revealed a "bird's beak" sign (Figure 1a).

SPECIFIC COMMENTS TO AUTHORS

well written manuscript. i have some suggestions. 1- how is the follow up of patient? 2-"distal esophagus obstruction may coexist with endocrine disease "

(10.5152/ejbh.2018.4132) and (https://doi.org/10.1016/j.ijsu.2018.04.037) I suggest both of these uptodate studies for the references.

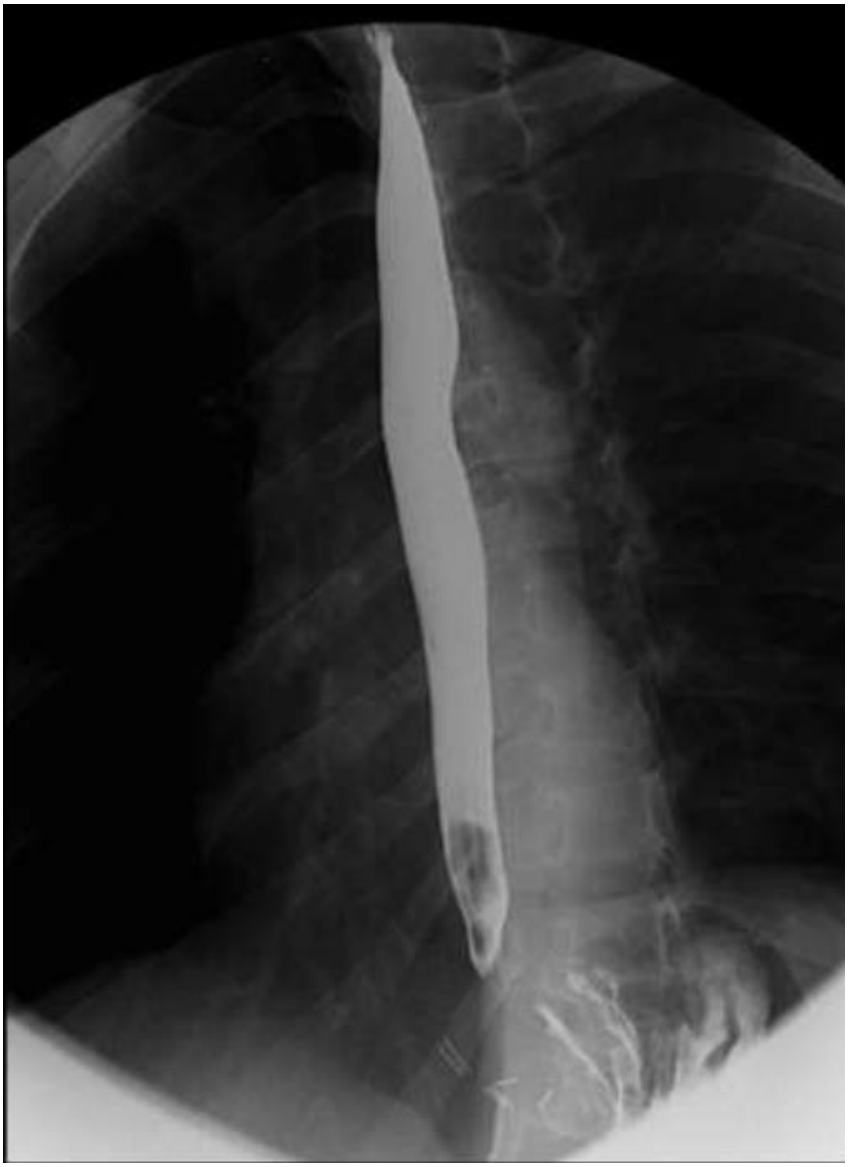
Thank you.

1 - how is the follow up of patient?

Outcome and Follow-up

At the 17-month follow-up visit, the patient reported no regurgitation and complete resolution of symptoms. A repeat barium swallow revealed no gastroesophageal obstruction and no esophageal dilation, compatible with complete radiologic resolution (Figure 1b).

Figure 1b – Postoperative normal barium swallow.



Nine months after the operation, both a repeat endoscopy and an esophageal manometry showed normal findings (Table 2).

Table 2 – Postoperative High Resolution Manometry

Lower Esophageal Sphincter		
	Normal Values	**Patient Values**
Localization		48 – 44
Resting Pressure	10 - 45	7.1

(mmHg)		
Residual Pressure (mmHg)	< 8	- 4
Relaxation	Completo	Complete
EGJ Length (cm)	3 - 5	4
Esophageal body		
Peristaltic Waves (%)	80 - 100	100

2-"distal esophagus obstruction may coexist with endocrine disease " (10.5152/ejbh.2018.4132) and (https://doi.org/10.1016/j.ijsu.2018.04.037) I suggest both of these uptodate studies for the references

We have not identified any correlantions between the both articles and the Esophagogastric junction outflow obstruction

SPECIFIC COMMENTS TO AUTHORS

The article proposes a new surgical procedure for EGJOO therapy. It would be useful to add in the discussion the motivations for which to prefer this procedure to others already in use and what advantages this offers to the patient over the others. Authors should also indicate when to use the procedure they propose and when this is not indicated.

We added this to the conclusion:

Thus, we believe that Heller myotomy should be combined to Dor fundoplication in the surgical treatment of EGJOO refractory to medical management. Young patients with this condition may be good candidates for surgical treatment. Conversely, surgical treatment of elderly patients with EGJOO may be riskier and yet hard to defend.