

ANSWERING REVIEWERS



Dec 30, 2013

Dear Editor,

Please find enclosed the edited manuscript in Word format (file name: 2429-review.doc).

Title: The management of *Helicobacter pylori* infection after gastric surgery

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On behalf of all authors, I appreciate the time and effort of the editors and reviewers in reviewing our work. The manuscript has been improved according to the suggestions of reviewers:

This review summarized current evidence regarding the management of *Helicobacter pylori* infection after gastric surgery. I have the following comments to improve this piece of work:

(1) Introduction, 1st paragraph: It should be noted that the meta-analysis (reference 2) included a redundant study (two papers from the same cohort) so the statement should be revised to be more conservative.

Response: We recognize the limitation of the meta-analysis including a redundant study. We modify our statement to be more conservative.

We add description in the paragraph "The authors suggest that *H. pylori* eradication

treatment reduces the risk of gastric cancer, but the risk is not abolished.”

(2) Page 10: There is a mistake that should be corrected: “The rate of *H. pylori* infection was higher for B-I patients or jejuna interposition than for B-I ($P < 0.05$).”

Response: We correct the mistake as following: *H. pylori* infection was confirmed in 55.6% of the B-I patients and 76.1% of the jejuna interposition patients. The rate of *H. pylori* infection was higher for jejuna interposition patients than for B-I ($P < 0.05$).

(3) Page 15: The effect of *H. pylori* eradication to prevent metachronous gastric cancer remains a controversial issue, especially for subjects who underwent endoscopic resection. Please add a table here to summarize the similarities and differences between at least the following three studies to highlight the controversy for tertiary prevention (for example, the treatment method, the case number, the definition of new cancers, and the follow-up period): ? Choi J, Kim SG, Yoon H, Im JP, Kim JS, Kim WH, Jung HC. Eradication of *Helicobacter pylori* After Endoscopic Resection of Gastric Tumors Does not Reduce Incidence of Metachronous Gastric Carcinoma. Clin Gastroenterol Hepatol. 2013 Oct 4. doi:pii: S1542-3565(13)01505-X. 10.1016/j.cgh.2013.09.057. [Epub ahead of print] ? Maehata Y, Nakamura S, Fujisawa K, Esaki M, Moriyama T, Asano K, Fuyuno Y, Yamaguchi K, Egashira I, Kim H, Kanda M, Hirahashi M, Matsumoto T. Long-term effect of *Helicobacter pylori* eradication on the development of metachronous gastric cancer after endoscopic resection of early gastric cancer. Gastrointest Endosc. 2012 Jan;75(1):39-46. doi: 10.1016/j.gie.2011.08.030. Epub 2011 Oct 21. ? Fukase K, Kato M, Kikuchi S, Inoue K, Uemura N, Okamoto S, Terao S, Amagai K, Hayashi S, Asaka M; Japan Gast Study Group. Effect of eradication of *Helicobacter pylori* on incidence of metachronous gastric carcinoma after endoscopic resection of early gastric cancer: an open-label, randomised controlled trial. Lancet. 2008 Aug 2;372(9636):392-7. doi: 10.1016/S0140-6736(08)61159-9.

Response:

The effect of *H. pylori* eradication to prevent metachronous gastric cancer remains a

Author	Year	Treatment method	Case number	metachronous cancer Eradication	metachronous cancer No eradication	Definition of new cancers	p value (95% CI)	Follow-up, yr
Choi [36]	2013 RCT	Endoscopic submucosal dissection	901	10/444	17/457	new carcinoma in areas of other than the site of primary gastric cancer	$p = 0.15$	3
Maehata [35]	2012 Retrospective	Endoscopic submucosal dissection	268	15/177	13/91	new carcinoma in areas other than the site of primary gastric cancer; at least 1 year after the endoscopic resection	$p = 0.262$	3
							$p = 0.007$	5
Fukase [34]	2008 RCT	Endoscopic submucosal dissection	544	9/272	24/272	new carcinoma in areas of other than the site of primary gastric cancer	$p = 0.009$	3

controversial issue. We reviewed the recent randomized controlled trials to highlight the controversy.

(4) Page 15: Also, please do not mix up the studies of partial gastrectomy and EMR/ESD; this paragraph is confusing and should be carefully revised. Please separate them into two different paragraphs.

Response: We separate them into two different paragraphs regarding partial ESD or gastrectomy.

(5) Page 18 and the final conclusion in Page 19: The authors suddenly moved from the recommendation of histology to the serology at this paragraph. However, serology test is in fact lower in the specificity for diagnosing current H. pylori infection despite its high sensitivity, which is not in keeping with the clinical practice. Please modify the statement regarding the clinical use of serology; the H. pylori stool antigen test or invasive test

would be a better option.

Response: We recommend that “For a good diagnostic tool with a sensitivity of more than 80%, a histological test is better than either the urea breath test (UBT) or rapid urease test (RUT) after gastrectomy” and “more than one diagnostic method be used to decrease the false-negative rate in such circumstances” in the Page 18.

We add additional description as following in the page 19 : Serology is the only test that is not affected by local changes in the stomach, “a combination of serology with histological test or *H. pylori* stool antigen test could be used to avoid false-negative results.”

Thank you again for publishing our manuscript in the *World Journal of Gastroenterology*.

Sincerely yours,

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