

January 16,2021
Dennis A Bloomfield
Bao-gan Peng
Sandro Vento
Editors-in-Chief
World Journal of Clinical Cases

Dear Editors:

We wish to re-submit our revised manuscript titled: “Pancreatic cancer secondary to intraductal papillary mucinous neoplasm with collision between gastric cancer and B-cell lymphoma: A case report.” The manuscript ID is 61776.

We thank you and the reviewers for your thoughtful suggestions and insights. The manuscript has benefited from these insightful suggestions. I look forward to working with you and the reviewers to move this manuscript closer to publication in your esteemed journal.

The manuscript has been rechecked and the necessary changes have been made in accordance with the reviewers’ suggestions. The responses to all comments have been prepared and attached herewith/given below. The revised passages below are marked in red font.

Thank you for your consideration. I look forward to hearing from you.

Sincerely,
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Revision – authors’ response

We would like to thank the referees for their thoughtful review of our manuscript. We believe that the additional changes we have made in response to the reviewers comments have made this a significantly stronger manuscript. Below is our point-by-point response to the referee’s comments.

Referee #1:

The referee correctly noted that our language was not the best.

Filipodia help us to provide a manuscript that is ‘publication ready’ – that is, it is guaranteed to reach all of specific requirements for Grade A status of its grammar, contextual and formatting that journal require.

Reviewer #2:

We want to begin by thanking Referee #2 for writing that “An interesting case that highlights a unique pancreatic and extrapancreatic malignant transformation after a confirmed diagnosis of an IPMN.” We also appreciated the constructive criticism and suggestion. We addressed all the points raised by the reviewer, as summarized below.

1. According to the referee’s suggestion, the histological features of pancreatic cancer and IPMN were described in detail in the D-I section of Fig2. The histological features of gastric cancer and DLBCL were described in detail in Part D-I of Figure 3.

Fig2.

D: Hematoxylin and eosin staining of the pancreatic tissue section shows dendritic and papillary growth of pancreatic cancer associated with localized calcification;

E: At high magnification, cancer cells show the papillary proliferation with necrosis at the center marked inside panel D;

F: The histological features of IPMN are cystic lesion composed of dilated ducts and with the cystic surface lined by a layer of columnar epithelial cells, with basal nuclei showing minimal atypia;

H-I: Serial sections were also immunohistochemically stained with antibodies against mucin (MUC) 1 (G) , MUC2 (H) and MUC5AC (I), but only MUC5AC was positively stained.

Fig3

D: Histological examinations revealed that the resected gastric specimen contained a small ulcerated lesion (approximately 5 mm in length) composed of atypical epithelial cells with large nuclei;

E: Tubular or papillary proliferation is present, but without submucosal invasion; F: Beneath the gastric carcinoma, there was diffuse infiltration of atypical lymphoid cells in the muscular propria. The yellow arrow indicates atypical lymphoid cells that are large in size, compared with the red arrow that indicates normal lymphocytes;

G-I: Immunohistochemical staining analysis, with brown staining showing abnormal lymphoid cells are positively stained with CD20 (G, H) but negatively stained with CD3 (I) .

2. Based on the referee's comment that to discuss the differential diagnoses in the discussion section, and demonstrate in details the histological and immunohistochemical similarities between them. We added the differential diagnosis in the discussion section and detailed the histological and immunohistochemical similarities.

In invasive pancreatic cancer, a low-echo mass with irregular contour can be seen on EUS, with uneven internal echo and a dilated pancreatic duct in the tail of the pancreas, and cystic lesions can be seen in branched IPMN using EUS, with uniform internal echo and sometimes intramural nodules, which need to be differentiated from mucous thromboembolism. Gastric DLBCL is often accompanied by ulcer formation; morphology similar to early gastric cancer is rare, while most is similar to advanced gastric cancer. Ulcer demarcation line is clear, with smooth uplift of the ulcer boundary.

Pathological analysis is essential to detect these malignant tumors. At high magnification, the pancreatic carcinoma cells show papillary hyperplasia with central necrosis in pancreas biopsy (Figure 2D and E). The histological features of IPMN were also found in pancreatic tissue sections. The cystic lesion is composed of dilated ducts, and the cystic surface is lined with a layer of columnar epithelial cells with basal nuclei showing minimal atypia (Figure 2F). Sequence

sections were immunohistochemically stained with antibodies to MUC1 (G), MUC2 (H), and MUC5AC (I), but only MUC5AC was positive (Figure 2 G-I).