Format for ANSWERING REVIEWERS

December 8, 2013

Dear Editor,

Please find enclosed the edited manuscript in Word format (file name: 6237-review).

Title: Anesthetic Perioperative Management Of Patients With Pancreatic Cancer

Author: De Pietri Lesley, Montalti Roberto, Begliomini Bruno

Name of Journal: *World Journal of Gastroenterology*

ESPS Manuscript NO: 6237

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

REVIEWR N° 1

QUERY 1. Good data is available that the presence of interventional radiologist is associated with reduced postoperative mortality please include interventional radiologists

ANSWER. *I agree, I have added in the text like suggested*

QUERY 2. Postoperative management: please include specifics about the management of patients who underwent total pancreatectomy (e.g. continuous insulin supplementation in early postoperative phase)

ANSWER. *I included in the text within the postoperative management, specifics about glycemic control and pancreatogenetic diabetes.*

QUERY 3. Several pancreatic centers are much more progressive in the fast track concept (valid for pancreatoduodenectomies as well as for left resections): extubation in the OR, immediate removal of gastric tube

after extubation, start drinking 6 hours postoperatively, start of solid food on POD 1 or 2.

ANSWER. *I perfectly agree with you. In our center we always procede to the extubation in the OR, as regard nasogastric tube several recent prospective studies have questioned nasogastric decompression, but the high incidence of delayed gastric emptying associated with pancreatic surgery has discouraged many surgeons from eliminating its use.*

Two historical case–control studies evaluated the role of nasogastric suction after pancreatic resection showing that insertion of nasogastric tube needs to be reconsidered in patients who undergo pancreatic resection[1, 2]

In our daily practice and at other authors' institution, nasogastric tube is routinely removed on postoperative day 1 after pancreaticoduodenectomy, and after the extubation in distal pancreatectomy[3] *We added this concept in the text.*

As regard fuilds and solid intake, potential benefits from early postoperative oral intake have been suggested[4]*. While fluid intake is frequently granted by the first postoperative hours, like you mentioned, with regard to the intake of solid foods are more rare the scientific works in which this shall be granted from the first postoperative day. Usually light solid foods are allowed in the second and third postoperative day*[5, 6]*.*

Our and other authors daily practice, involves oral light food intake starting from postoperative day 2[3] *In patients at risk of postoperative complications such as pancreatic fistula or abdominal collections, we promote the use of combined parenteral and enteral nutrition.*

I made the corrections in the text.

QUERY 4: Introduction, third paragraph: …to be one of the key criterion…. There are several more, e.g. interventional radiology (see above).

ANSWER. *I made the correction.*

QUERY 5. Preoperative risk assessment: Please do not include "biliary stenting" or discuss critically. Biliary stenting increases septic complications and should only be performed when necessary (high bilirubin with associated coagulation dysfunction). Icteric patients without coagulation disorder should be operated as soon as possible

ANSWER. *Your observation is right. I deleted from the text this concept*

QUERY 6. Table 1 includes mechanical bowel preparation. This needs to be deleted since it has no value in pancreatic surgery. "Minimal invasive surgery" is placed in the postoperative row. Please delete. It is very controversial if minimal invasive pancreatic surgery, which is associated with significantly longer operating times, is beneficial.

ANSWER. *You are right. I made the deletion of mechanical bowel preparation from Table 1 and I better clarified this concept in the text.*

I made the deletion of "minimal invasive surgery" from the postoperative row in Table 1, and from the text in the postoperative paragraph.

QUERY 7. Table 2: "Thoracic surgery" needs to be deleted, since not typical for pancreatic surgery. Table legends include "perioperative", bit should better say "perioperative". Does "prolonged hospitalization" include the pre- and postoperative time?

ANSWER. *Sorry for the mistake, I deleted "thoracic surgery" from the Table 2. I made the correction in the legend as well.*

1. *Choi YY, Kim J, Seo D, et al. Is routine nasogastric tube insertion necessary in pancreaticoduodenectomy? J Korean Surg Soc 2011; 81(4):257-62.*
2. *Fisher WE, Hodges SE, Cruz G, et al. Routine nasogastric suction may be unnecessary after a pancreatic*

resection. HPB (Oxford) 2011; 13(11):792-6.

3. *Salvia R, Malleo G, Butturini G, et al. Perioperative management of patients undergoing pancreatic resection: implementation of a care plan in a tertiary-care center. J Surg Oncol 2013; 107(1):51-7.*
4. *Moore FA, Feliciano DV, Andrassy RJ, et al. Early enteral feeding, compared with parenteral, reduces postoperative septic complications. The results of a meta-analysis. Ann Surg 1992; 216(2):172-83.*
5. *di Sebastiano P, Festa L, De Bonis A, et al. A modified fast-track program for pancreatic surgery: a prospective single-center experience. Langenbecks Arch Surg 2011; 396(3):345-51.*
6. *Berberat PO, Ingold H, Gulbinas A, et al. Fast track--different implications in pancreatic surgery. J Gastrointest Surg 2007; 11(7):880-7.*

REVIEWR N° 2

ANSWER. *We have made the review shorter and the content less extensive, but I had to add a new paragraph about postoperative glycemic control after total pancreatectomy like asked by another reviewer.*

I apologize for the references literature: the most recent papers are missing the date of publishing because the EndNote program did not add these informations to e-pub articles. We fixed it.

3 References and typesetting were corrected

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

Sincerely yours,

De Pietri Lesley

Dr. De Pietri Lesley
c/o Anesthesia and Intensive Care Unit 1.

Azienda Ospedaliero-Universitaria di Modena-Policlinico

71 via del Pozzo. 41100 Modena (Italy).

Phone: +39-059-4225864. Fax +39-059-4223765.

E-mail: lesley.depietri@yahoo.it