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24th April 2021

Editor in Chief

World Journal of Gastrointestinal Surgery

Dear Editor,

We would like to thank you and the reviewers for the meticulous and constructive feedback on our manuscript.

We would like to respond to the queries from the reviewers as the followings:

I would like to thank for the opportunity to revise this manuscript. This was a systematic review on chylous ascites after colorectal surgery. The Authors included all case reports, studies and one trial on colorectal surgery (both for malignant and benign lesions) published on PUBMED. The main findings of this study was that prevalence of chylous ascites was about 5.5%, even if most of the studies were case series or case reports (therefore the actual prevalence can be over-estimated). The Authors did not find robust evidence about significant risk factors for chylous ascites. However, a low percentage of patients required surgery.

My comments: - I agree with the fact that metanalysis was not appropriate, given the high number of case reports/case series. - As mentioned by the Authors, the definition of chylous ascites was heterogeneous among studies, therefore data coming from different studies may be difficult to compare to each other. Similarly, treatment algorithm differed across different studies. - Why patients with chylous ascites displayed more DFS? This point may be clarified (it has been reported only in one study). Different disease stage(s), and therefore type(s) and extent of surgery may play an important role (both on chylous ascites and DFS).

As correctly mentioned, only one study reported the long-term disease-free survival and overall survival. The patients who developed post-operative chylous ascites had shorter DFS but similar overall survival at 3-year. This could be explained by the more advanced disease stage (both stage 3a and stage 3b), requiring more extensive lymphadenectomy which predisposed to chylous ascites.

- According to the Authors' opinion, what could be the composition of the multidisciplinary team for the treatment of chylous ascites?

The ideal multidisciplinary team for the management of chylous ascites should include the treating clinician, allied health (nursing, dietician and physiotherapist) and a clinical psychologist (for patients with prolonged stay).

Reviewer #2

There are many case reports in the cited references, and I don't think the reviews have a high level of evidence.

Thank you for your comment. Unfortunately, due to the rarity of the condition reported in the literature, we decided to include case reports.

We await to hear from you.

Kind regards,

ZN