

## Letter to the Editor

*Dear Editor,*

Thank you very much for giving us this opportunity to revise our manuscript entitled ‘ Contrast-enhanced ultrasound of a traumatic neuroma of the extrahepatic bile duct: A case report and review of literature’ (75670). On behalf of our co-authors, we appreciate reviewers very much for their positive and constructive comments and advice on our manuscript. We would like to revise our manuscript according to the comments of reviewers and yours. We will submit a revised one within the time limit. The comments have been carefully taken into consideration by all our authors and the followings are our response to your and the reviewers’ comments.

Reviewer #1:

Scientific Quality: Grade B (Very good)

Language Quality: Grade B (Minor language polishing)

Conclusion: Accept (General priority)

Specific Comments to Authors: Interesting case report and a good review of literature. My understanding from review of literature is that a biliary-enteric continuity in a transected bile duct is best achieved with a Hepatico-Jejunostomy especially when the anastomosis or discontinuity is higher up. I am curious why the authors chose end to end versus Hep-jejunosotomy?

**Reply:** Thank you for your encouragement and comments. We know that by looking at the literature there are contradictory reports on the effectiveness of bile duct reconstruction methods of iatrogenic bile duct injuries in the literature. Although hepaticojejunosotomy (HJ) is the frequently recommended type of reconstruction, it is also controversial about indications, surgical options and suture selection. Some investigators also recommend end-to-end ductal anastomosis (EE) because it is more

physiological and can maintain the physiological balance<sup>[1]</sup>. This study<sup>[2]</sup> emphasizes that it is possible to achieve very good long-term results and high quality of life using both HJ and the EE. And the lower number of early postoperative complications after EE is also favorable. And EE strictures can be easily dilated endoscopically in contrast to HJ<sup>[3]</sup>. So they recommend EE for patients when it is possible to dissect and approximate both the proximal and distal ductal ends without tension.. Intraoperative pathology showed no tumor cells and no local metastasis in our patient. At the same time, the surgeon found the anastomosed edges blood supply is good and no tension of the anastomosed edges. Therefore, according to the actual conditions of patients, as well as in order to maintain the physiological balance, our hospital professor implemented EE for this patient. We also add this part to our discussion. Thank you again sincerely for your review and valuable questions.

**Changes in the text:**

Page 8-9, line 206-217 (DISCUSSION): “Although hepaticojejunostomy is the frequently recommended type of reconstruction, it is also controversial about indications, surgical options and suture selection. Some investigators also recommend end-to-end ductal anastomosis because it is more physiological and can maintain the physiological balance [33]. It is possible to achieve very good long-term results and high quality of life using both hepaticojejunostomy and end-to-end ductal anastomosis, when it is feasible for the proximal and distal ductal ends to permit end-to-end ductal anastomosis [34]. So the choice of the optimum method is strictly correlated with the morphological nature of the lesion, which is different from one stage to the other, depending upon the moment of detection, and therefore have different surgical implications [35]. At the same time, the surgeon found the anastomosed edges blood supply is good and no tension of the anastomosed edges. Therefore, according to the actual

conditions of patients, as well as in order to maintain the physiological balance, our hospital professor implemented EE for this patient.”

#### REFERENCES

- 1 Górką Z, Ziaja K, Wojtyczka A, Kabat J, Nowak JJPJS. End-to-end anastomosis as a method of choice in surgical treatment of selected cases of biliary handicap. *Pol J Surg* 1992; **64**: 977-979
- 2 Jabłońska B, Lampe P, Olakowski M, Górką Z, Lekstan A, Gruszka T. Hepaticojejunostomy vs. end-to-end biliary reconstructions in the treatment of iatrogenic bile duct injuries. *J Gastrointest Surg* 2009; **13**(6): 1084-1093 [PMID: 19266245 DOI: 10.1007/s11605-009-0841-7]
- 3 Jabłońska B. End-to-end ductal anastomosis in biliary reconstruction: indications and limitations. *Canadian journal of surgery Journal canadien de chirurgie* 2014; **57**(4): 271-277 [PMID: 25078933 PMCID: PMC4119121 DOI: 10.1503/cjs.016613]

Reviewer #2:

Scientific Quality: Grade B (Very good)

Language Quality: Grade B (Minor language polishing)

Conclusion: Accept (General priority)

Specific Comments to Authors: Congratulations for this very interesting clinical case presentation as well as for the meticulous literature review. The case itself is a very interesting and complicated example of postoperative traumatic neuroma that can pose a real challenge not only in terms of treatment, but for the very diagnosis itself, that, without the use of high-resolution contrast-enhanced US or cholangio-MRI, is next to impossible, forcing a laparoscopic approach for establishing the diagnosis. However, a minor objection would be regarding the surgical choice for re-establishing the continuity of the resected main biliary pathway. In my personal opinion, and several studies have shown this (A Proposed Therapeutic Algorithm Based on

Multiple Case Analysis Regarding the Repair Options of Iatrogenic Biliary Lesions Following Open and Laparoscopic Surgery. JMMS, Vol. 3, Issue 2, Article 8, (2016), p162-171. <http://scholar.valpo.edu/jmms/vol3/iss2/8>. ISSN: 2392-7674), taken from repairing several main biliary pathway iatrogenic bile duct injuries, end-to-end biliary pathway anastomosis is more than often associated with a high rate of stenosis, as a long-term complication. Perhaps a choledochal-to-jejunum end-to-side anastomosis would have been a better choice, credited with a better overall and longtime chances of evolving without complications. Overall, a very good paper and congratulations, once again, for sharing this experience with us.

**Reply:** Thank you for your encouragement and comments. At the same time, thank you for providing me with this literature to further improve my understanding. As mentioned in this literature, the choice of the optimum method is strictly correlated with the morphological nature of the lesion, which is different from one stage to the other, depending upon the moment of detection, and therefore have different surgical implications. Though hepaticojejunostomy (HJ) is the frequently recommended type of reconstruction, it is also controversial about indications, surgical options and suture selection. Some investigators also recommend end-to-end ductal anastomosis (EE) because it is more physiological and can maintain the physiological balance<sup>[1]</sup>. This study<sup>[2]</sup> emphasizes that it is possible to achieve very good long-term results and high quality of life using both HJ and the EE. And the lower number of early postoperative complications after EE is also favorable. So they recommend EE for patients when it is possible to dissect and approximate both the proximal and distal ductal ends without tension. And EE strictures can be easily dilated endoscopically in contrast to HJ<sup>[3]</sup>. Intraoperative pathology showed no tumor cells and no local metastasis in our patient. At the same time, the surgeon found the anastomosed

edges blood supply is good and no tension of the anastomosed edges. Therefore, according to the actual conditions of patients, as well as in order to maintain the physiological balance, our hospital professor implemented EE for this patient. We also add this part to our discussion. Thank you again sincerely for your review and valuable questions.

**Changes in the text:**

Page 8-9, line 206-217 (DISCUSSION): “Although hepaticojejunostomy is the frequently recommended type of reconstruction, it is also controversial about indications, surgical options and suture selection. Some investigators also recommend end-to-end ductal anastomosis because it is more physiological and can maintain the physiological balance [33]. It is possible to achieve very good long-term results and high quality of life using both hepaticojejunostomy and end-to-end ductal anastomosis, when it is feasible for the proximal and distal ductal ends to permit end-to-end ductal anastomosis [34]. So the choice of the optimum method is strictly correlated with the morphological nature of the lesion, which is different from one stage to the other, depending upon the moment of detection, and therefore have different surgical implications [35]. At the same time, the surgeon found the anastomosed edges blood supply is good and no tension of the anastomosed edges. Therefore, according to the actual conditions of patients, as well as in order to maintain the physiological balance, our hospital professor implemented EE for this patient.”

**REFERENCES**

- 1 Górká Z, Ziaja K, Wojtyczka A, Kabat J, Nowak JJPJS. End-to-end anastomosis as a method of choice in surgical treatment of selected cases of biliary handicap. *Pol J Surg* 1992; **64**: 977-979
- 2 Jabłońska B, Lampe P, Olakowski M, Górká Z, Lekstan A, Gruszka T. Hepaticojejunostomy vs. end-to-end biliary reconstructions in the

treatment of iatrogenic bile duct injuries. *J Gastrointest Surg* 2009; **13**(6): 1084-1093 [PMID: 19266245 DOI: 10.1007/s11605-009-0841-7]

3 Jabłonska B. End-to-end ductal anastomosis in biliary reconstruction: indications and limitations. *Canadian journal of surgery Journal canadien de chirurgie* 2014; **57**(4): 271-277 [PMID: 25078933 PMCID: PMC4119121 DOI: 10.1503/cjs.016613]

#### 4 LANGUAGE POLISHING REQUIREMENTS FOR REVISED MANUSCRIPTS SUBMITTED BY AUTHORS WHO ARE NON-NATIVE SPEAKERS OF ENGLISH

As the revision process results in changes to the content of the manuscript, language problems may exist in the revised manuscript. Thus, it is necessary to perform further language polishing that will ensure all grammatical, syntactical, formatting and other related errors be resolved, so that the revised manuscript will meet the publication requirement (Grade A).

Authors are requested to send their revised manuscript to a professional English language editing company or a native English-speaking expert to polish the manuscript further. When the authors submit the subsequent polished manuscript to us, they must provide a new language certificate along with the manuscript.

**Reply:** Thank you for your advice. We have sent the revised manuscript to American Journal Experts and provided a new language certificate along with the manuscript.

#### 5 ABBREVIATIONS

In general, do not use non-standard abbreviations, unless they appear at least two times in the text preceding the first usage/definition. Certain commonly used abbreviations, such as DNA, RNA, HIV, LD50, PCR, HBV, ECG, WBC, RBC, CT, ESR, CSF, IgG, ELISA, PBS, ATP, EDTA, and mAb, do not need to be defined and can be used directly.

**Reply:** Thank you for your comments. We have checked the full

text and revised the ABBREVIATIONS in the manuscript according to the rules.

### **Changes in the text:**

Page5, line 114-119 (Laboratory examinations): The liver function tests demonstrated increased levels of alanine aminotransferase (~~ALT~~) (185 IU/L, normal range:<50 IU/L), aspartate aminotransferase (~~AST~~) (148 IU/L, normal range:<40 IU/L) and total bilirubin (~~TB~~) (37.0 µmol/L, normal range: 5-28 µmol/L). Tumor markers included carbohydrate antigen-~~(CA)~~ 199 (98.6 U/ml, normal range: <22 U/ml), carcinoembryonic antigen-~~(CEA)~~ (0.97 ng/ml, normal range: <5 ng/ml), and alpha-fetoprotein (~~AFP~~) (4.67 ng/ml, normal range: <7 ng/ml).

Page8, line 193-196 (DISCUSSION): **magnetic resonance cholangiopancreatography** instead of MRCP; **endoscopic ultrasound** instead of EUS; **contrast-enhanced harmonic endoscopic ultrasonograph** instead of CEUS; **intraductal ultrasonography** instead of IDUS.

## **6 EDITORIAL OFFICE'S COMMENTS**

Authors must revise the manuscript according to the Editorial Office's comments and suggestions, which are listed below:

### **(1) Science editor:**

This is an interesting clinical case on imaging data of a rare complication of surgical treatment of the digestive system diseases with a brief review of published information on this topic. Reviewers highly appreciated this manuscript. However, it is necessary to use the abbreviated names of the journals in the list of references. In addition, "CA199" should be corrected for "CA19-9". After these correction, I believe that this manuscript can be published in the World Journal of Gastroenterology.

Language Quality: Grade B (Minor language polishing)

Scientific Quality: Grade B (Very good)

**Reply:** Thank you for your encouragement and comment. We

have checked the full text and revised the spell of 199.

**Changes in the text:** Page3, line 54 (CASE SUMMARY): 19-9 instead of 199; Page5, line 117 (Laboratory examinations): 19-9 instead of 199.

(2) Company editor-in-chief:

I have reviewed the Peer-Review Report, the full text of the manuscript, and the relevant ethics documents, all of which have met the basic publishing requirements of the World Journal of Gastroenterology, and the manuscript is conditionally accepted. I have sent the manuscript to the author(s) for its revision according to the Peer-Review Report, Editorial Office's comments and the Criteria for Manuscript Revision by Authors. Before final acceptance, uniform presentation should be used for figures showing the same or similar contents; for example, "Figure 1 Pathological changes of atrophic gastritis after treatment. A: ...; B: ...; C: ...; D: ...; E: ...; F: ...; G: ...". Please provide decomposable Figures (in which all components are movable and editable), organize them into a single PowerPoint file. Please authors are required to provide standard three-line tables, that is, only the top line, bottom line, and column line are displayed, while other table lines are hidden. The contents of each cell in the table should conform to the editing specifications, and the lines of each row or column of the table should be aligned. Do not use carriage returns or spaces to replace lines or vertical lines and do not segment cell content. In order to respect and protect the author's intellectual property rights and prevent others from misappropriating figures without the author's authorization or abusing figures without indicating the source, we will indicate the author's copyright for figures originally generated by the author, and if the author has used a figure published elsewhere or that is copyrighted, the author needs to be authorized by the previous publisher or the copyright holder and/or indicate the reference source and copyrights. Please check and confirm whether the

figures are original (i.e. generated de novo by the author(s) for this paper). If the picture is 'original', the author needs to add the following copyright information to the bottom right-hand side of the picture in PowerPoint (PPT): Copyright ©The Author(s) 2022.

**Reply:** Thank you for your comment. We changed the figures and tables according to your request. We checked and confirmed that all the figures are original and added "Copyright ©The Author(s) 2022" in the picture in PowerPoint (PPT).

Thanks again!

Yan Luo,

Email: yanluo@scu.edu.cn