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Editors-in-Chief  
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Re: Point by point response: “Clinical Impact of self-expanding metal stents (SEMS) in patients with malignant colorectal obstruction: A systematic review and meta-analysis”

Dear editors,

I am grateful to the reviewers comment. Comments from reviewers certainly helped us to refine our manuscript to better level. Please find below point by point response to the comments of the reviewers:

**Reviewer No: 00042065**

A good systemic review of the current literature with take home message.

**Reviewer No: 00044509**

Major 1. As mentioned in the discussion, the period of SEMS replacement is greatly different between palliation and BTS. The author should describe the period of SEMS replacement about each procedure.

*The reviewer correctly point out that the period of SEMS replacement is different between palliation and BTS. Typically in BTS cases, surgery is performed within first 2 weeks of stent placement. We have done subgroup analysis for palliation and BTS group and reported the outcomes in Table 2. There were several studies which did not differentiate between BTS and palliation group in reporting the final outcomes and these studies were not included in subgroup analysis.*

2. Concerning complications, it seems to be important when serious complication occur after SEMS replacement. The authors should describe and discuss the time of each complication.

*Reviewer has correctly highlighted time for serious complications after stent placement is very important. Within limitation of meta-analysis specific time of each complication was not reported*

*in included studies, however, studies did report complication rates based on indication-if stents were placed for palliation or for bridge to surgery. We were able to do subgroup analysis based on indication for each complication and this is highlighted in Table 2B. Overall, stent migration were seen more often in palliation group suggesting delayed complication, while perforation rates were similar in both group suggesting early complication after stent placement.*

3. It is good to check the type of SEMS type. Covered stent could be better than uncovered stent in terms of preventing tumor ingrowth. Also, nitinol stent could merely perforate because of less axial force. The author should analyze the differences of stent types.

*Covered stent do prevent tumor ingrowth, however carries very high rate of stent migration and most commercially available colon stents are uncovered stent now-a-days. There was not sufficient data reported in the studies to do further analysis based on stent type.*

**Reviewer No: 03259495**

General comments: Profound review and assessment of the literature regarding relevant issue of endoscopy and oncology, till now not available in such detail. Highly sophisticated statistical analysis. Well written manuscript with extensive tables and understandable arguments in the discussion.

Specific comments: Clear disposition of all parts of the paper.

The very strict selection policy – of 2157 initially accumulated papers only 30 (? 1, 4 %) were included for analysis – should be discussed in more extent. The same holds true for the fact, that a broad variety of stents, including specific stents for the oesophagus as well as obsolete prostheses were used in the studies; even here a more detailed discussion is necessary.

*To review all published literature and ensuring no relevant studies are missed in the meta-analysis, our initial search strategy was very broad and based on pre-defined inclusion and exclusion criteria we identified 30 studies to be included in the meta-analysis. Initial studies did include esophageal stent and other stent types which are not used in current clinical practice. We have highlighted stent types used in each individual studies in detail (Figures). This also highlights evolving nature of technique and tools for colon stent placement. Our inclusion and exclusion criteria were decided before the literature search, and each study was selected based on pre-defined criteria.*

Regarding clinical impact of “bridge to surgery” in an emergency situation, the effective and cheap method of endoscopic application of a decompression tube should be mentioned at least as an alternative method.

*Nasogastric tubes, urinary bladder catheters as well as rectal tube have been used for decompression and as “bridge to surgery”. However, this is limited to case reports and case series and we did not*

*come across any retrospective, prospective or randomized trial attesting to efficacy of these devices, especially in ensuring good and adequate bowel preparation prior to colon surgery.*

Thank You  
Nirav C. Thosani  
MD MHA

Dated  
07/31/2015