September 28, 2022

Revised Manuscript submission to World Journal of Clinical Cases

Dear Editor in Chief

Thank you for inviting us to submit a revised draft of our manuscript entitled, "Phlegmonous gastritis after biloma drainage: A rare case report and literature review" to World Journal of Clinical Cases. We also appreciate the time and effort you and each of the reviewers have dedicated to providing insightful feedback on ways to strengthen our paper. Thus, it is with great pleasure that we resubmit our article for further consideration. We have incorporated changes that reflect the detailed suggestions you have graciously provided. We also hope that our edits and the responses provided below satisfactorily address all the issues you and the reviewers have noted.

To facilitate your review of our revisions, the following is a point-by-point response to the questions and comments delivered in your letter dated September 26th 2022. The line, paragraph and section are tagged to facilitate reviewer to find the revision.

Reviewer #1 comments:

Scientific Quality: Grade C (Good)

Language Quality: Grade B (Minor language polishing)

Conclusion: Minor revision

1. It has been mentioned in the literature that phlegmonous gastritis can be classified as one of two types depending on the extent of the disease: diffuse and localized, and gastric wall abscess is a localized form of phlegmonous gastritis. What is your opinion on this classification? And all of the cases belong to diffuse form of phlegmonous gastritis in your article?

Response: Thank you for the kind remind. After attentively reviewing the literature, PG is classified into diffuse and localized type according to the lesion range. Diffuse involves the complete stomach, conversely localized disease, most commonly is restricted to the antrum. Gastric wall abscess is a localized form of phlegmonous gastritis and the most of PG is belonged to diffuse type. In our literature view, only 6 cases are localized type. (line1 to 6, paragraph 2 in discussion section)

2. It would be worth adding the literature of other risk factors of PG, such as ESD, EMR, ERCP and so on.

Response: We had mentioned that one of risk factor of PG is prior endoscopic procedure. After revising, we had mentioned the prior endoscopic procedure including endoscopic mucosal resection, endoscopic submucosal dissection, endoscopic hemostasis, endoscopic ultrasonography with fine needle aspiration, mucosal biopsy. (line12 to 15, paragraph 1 in discussion section)

3. When were the EGD and abdominal CT reviewed after discharged from hospital? Please state in the article.

Response: follow-up EGD was performed one month later and Follow-up abdominal CT was performed two months later. (line1 and 3, paragraph 1 in outcome and follow-up section)

4. Endoscopic ultrasonography for phlegmonous gastritis diagnosis is reportedly effective. Please discuss the role of endoscopic ultrasonography in the diagnosis of this disease if possible

Response: EUS has not been routinely recommended but is an excellent tool for marking thickening of the gastric wall and degree of inflammation. (line15-17, paragraph 3 in discussion)

5. Please add the differential diagnosis (scirrhous gastric cancer or acute gastric mucosal lesion?) and overall prognosis (complications or recurrence after discharge?) of phlegmonous gastritis in the discussion section.

Response: We had added differential diagnosis and overall prognosis in the discussion section. For differential diagnosis of PG, acute gastric mucosal lesion, scirrhous gastric cancer, gastric syphilis, corrosive gastritis, malignancy lymphoma of the stomach, GI stromal tumor and anisakiasis need to be considered. (line9-11, paragraph 3 in discussion)

The complications of PG include delayed perforation, abdominal compartment syndrome, bleeding, stricture. (line12-13, paragraph 5 in discussion)

The recurrent rate of PG is low according to our literature review. Only one case which was reported by Taniguchi et al had recurrent PG 5 days after discharge and the reasons for recurrence maybe due to steroid treatment for allergy and short-term course of antibiotics. (line1-4, paragraph 6 in discussion)

6. Surgery should always be considered in refractory cases and in the presence of complications. Please try as much as possible to describe in detail

the role of the surgery in the treatment of this condition.

Response: Surgery should always be considered in refractory cases, that is clinical deterioration despite optimal medical management and in the presence of complications. Surgery can be partial or total gastrectomy according to the range of inflammation. (line10-15, paragraph 5 in discussion)

Reviewer #2 comments:

Scientific Quality: Grade D (Fair)

Language Quality: Grade C (A great deal of language polishing)

Conclusion: Major revision

1. Figures esp. Endoscopy ones need to be of better quality

Response: Thanks a lot for your suggestion. We had changed the better-quality figures in endoscopy.

2. Case report has not been in WJG style/protocol. English language also needs to be improved.

Response: We had sent our revised manuscript to a professional English language editing company, Filipodia. It had polished the manuscript and conformed the WJG protocol. This manuscript had received Grade A of language quality by Filipodia.

3. In Discussion you need to add one full paragraph regarding unusual clinical scenario of spontaneous biliary rupture and it's clinical presentations spectrum. Add two important recent references regarding spontaneous biliary rupture or perforation from India.....Amit Soni et al, J Gastroenterol Hepatol 2015 and Sanjeev Sachdeva et al, Indian J Gastroenterol 2021.

Response: I had added two paragraphs to introduce spontaneous biliary rupture according to two references the reviewer suggested. (paragraph 7 and 8 in discussion)

Reviewer #3 comments:

Scientific Quality: Grade A (Excellent)

Language Quality: Grade A (Priority publishing)

Conclusion: Accept (High priority)

1. Good

Response: Thanks a lot for your positive review.

Again, thank you for giving us the opportunity to strengthen our manuscript with your valuable comments. We have worked hard to incorporate your feedback and hope that these revisions persuade you to accept our submission.

Your sincerely,

Dr. Jui-Wen Kang, MD
Department of Internal Medicine, National Cheng Kung University Hospital, College of Medicine, National Cheng Kung University, 138 Sheng Li Road, Tainan, Taiwan, 70428.
E-mail: kang1594@gmail.com