**RESPONSE TO REVIEWERS**

**Nov 18, 2012**

**Dear Editor,**

**Please find enclosed the edited manuscript in Word format (file name: wjgie-manuscript ERCP-corrected).**

**Title: ERCP under moderate sedation and factors predicting need for anesthesiologist directed sedation- A County Hospital Experience.**

**Author: Saurabh Chawla MD, Ariel Katz MD, Bashar M Attar MD, PhD, Benjamin Go MD**

**Name of Journal: World Journal of Gastrointestinal Endoscopy**

**ESPS Manuscript NO: 107**

**The manuscript has been improved according to the suggestions of reviewers:**

**1. Revision has been made according to the suggestions of the reviewer**

**Please see the following page for reviewer’s comments and our revisions and response.**

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

**Sincerely yours,**

**Saurabh Chawla MD**

**Division of Gastroenterology,**

**Department of Medicine**

**Room # 1435, 14th Floor**

**1900 W Polk Street**

**Chicago, IL 60612**

[**schawla2@gmail.com**](mailto:schawla2@gmail.com)

**MAJOR POINT:**

*1) The authors attempted to evaluate the failure of Gastroenterologist-directed sedation (GDS) with midazolam and opioids for ERCP. In there analysis, however, they censored all ERCP-failures including anatomical reasons (e.g. BII-anatomy, duodenal diverticula, residual food in the stomach etc.) and every case of not gaining access to the desired duct (n=40/68) as a failure of GDS. How they can be sure that this were sedation-related failures ? Were they successful in all these cases when ERCP was repeated under monitored anaesthesia-care (MAC) ?*

**Response:** We thank the reviewer for this important observation regarding Table 3. The percentages in parenthesis in the table are based on the total number of patients who underwent Gastroenterologist-directed sedation (GDS) and were included in the analysis (n=486). This has been reported in line 150, page 7. As the reviewer noted, there were 40 patients where we could not gain access to the desired duct. However, these patients were out of 486 patients in whom GDS was attempted. Therefore they made up 8% (40/486) patients in whom GDS was attempted. The failed cannulation rate was similar in patients who had GDS and primary ADS (Anesthesiologist directed sedation) and this has been reported in line 158, page 7.

Finally, patients who had failed cannulation but were otherwise not reported as being intolerant or having sedation related complications were excluded from the analysis. We have updated our manuscript to reflect this important point and amended the table as well.

*Minor points:*

*1. Methods: The authors should give the mean patient age, the distribution of the ASA-class 1 and 2 and the mean body weight in order to allow an interpretation of the used benzo and narco dosages. The evaluation of the patient races may be for example not so interesting for other parts of the world outside the U.S. Did the patients age and body weight have any impact on the ERCP failure rate ?*

**Response:** We thank the reviewer for this observation. We did include age as one of the patient variables which may result in failure of GDS- line 128, page 6. To better study age, we divided the patients as less than or equal to 65 yrs and more than 65 yrs for our analysis. Table 4 shows our results which demonstrate that there was no significant influence of age on failure of sedation. In our retrospective study we did not collect data about body weight and distribution of ASA class in the GDS group.

*2. Biostatistics: The authors should comment why they use a p < 0.1 as significance level. They should further state if some of there significant differences may be removed in case of using a correction for multiple testing (i.e. Bonferroni correction) ?*

**Response:** We thank the reviewer for this important observation. We used p <0.05 as a significance level and have corrected the manuscript to correct this ( Line 146, page 7). We did not use the Bonferroni correction because we initially did the univariate analysis and then adjusted for substance abuse. Subsequently we did a multivariate analysis.

*3)* *Discussion, page 9-10, para 6: Capnography was not used in order to evaluate the deep of sedation (this could be estimated by using EEG-monitoring) but to monitor the patients respiratory activity more closer. Please correct.*

**Response:** We thank the reviewer for this important correction and have edited the manuscript to reflect this- line 215, page 10.