

June 22, 2014

Dear Editor,



Please find enclosed the edited manuscript in Word format (file name: 11134-review.doc).

Title: Transanal endoscopic microsurgery (TEM): The first attempt in treatment of localized rectal amyloidoma

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

Reviewer 00057665: "Since the authors highlight that this is the first report in the literature on the use of this approach for such a lesion, a more detailed explanation discussing why TEM (a more expensive technique) was used as opposed to conventional transanal excision, or even TAMIS seems to be appropriate."

(1): We have expounded on this within our discussion (highlighted within "discussion") per the reviewer's suggestion. Briefly, the TEM allows for far superior visualization due to the ease of keeping adequate insufflation. TAMIS is a good alternative as well but since the lesion was fairly low, the TAMIS device was not fit to perform the procedure this low while keeping the device in place and keeping insufflation so that the lesion could be clearly seen and removed with adequate margins. This was best achieved with TEM.

Reviewer 00009776: "The mass occupying 50% of the rectal lumen located 2 cm from the dentate line. I think TEM may not be necessary, because it can be removed transanal easily. After excised the mass, they leave the defect open, why? It should be closed with absorbable suture. Schematic 1 should be deleted."

(2): Yes it can be approach transanally but the TEM has many advantages compared with the transanal technique as we have described in the discussion.

(3): Per your suggestions, we have explained the reason for leaving the defect open within "surgical technique and post-op" section. It was difficult to close the defect due to its size, and a lack of bleeding after cautery. In previous TEM cases, complications such as abscess and increased pain were noted by closing the defect.

(4): Schematic was has been deleted.

Reviewer 00503405: "The resected tumor mass was close to the anus. Was the lesion closed by clipping? If not, post-intervention bleeding occurred? How was the postoperative continence of the male patient?"

What kind of amyloid was found in the resected tumor mass?"

(5): The lesion was left open and no post-op bleeding occurred. This has been added into

“surgical technique and post-op” section.

(6): Gas incontinence 2 weeks post op and then normal bowel habits after. This has been added into “surgical technique and post-op” section.

(7): The patient had localized rectal amyloid deposition without systemic amyloid disease. This amyloid deposition is a general acellular, homogeneous, and eosinophilic material deposited uniformly throughout the mass. This description is included in the figure legend.

Reviewer 00043262

“The CT scan included reveals a paucity of free gas though this was not described in the case presentation. What was the etiology of this gas? was the pt systemically ill?”

(8): This is a great observation, which we failed to mention. There is a thickening of the left lower rectal wall with adjacent free gas, which is due to the tumor that had locally perforated. We will include this in the “case study” section. This is already mentioned in the figure legend.

“The area is described at 2cm from the dentate line and 50% circumference. Why was TEM chosen for such a low lesion that could have been approached easily transanally?”

(9): Yes it can be approach transanally but the TEM has many advantages compared with the transanal technique as we have described in the discussion.

“At times it is difficult to maintain CO2 distension for such low lesions due to positioning of the rectoscope. Was this the case? Was the flat or beveled rectoscope utilized?”

(10): We used a beveled scope, which made it possible to maintain insufflation allowing great visualization of the lesion. We will include this in “surgical technique and post-op” section.

“It is also difficult to visualize a 5cm , 50% circumference lesion via the TEM scope. Can the authors describe this further? Also, beginning 1cm distal must have included some of the internal sphincter. Was this the case?”

(11): The diameter of the patient’s rectum was too big to keep the lesion in the center so after distal mobilization, the lesion retracted and the edges of the mucosa separated, which helped to visualize the lesion. Yes, small fibers of the internal sphincter were in the specimen but post op he did not have any incontinence. We will include this detail within the “surgical technique and post-op” section.

“Can you comment on the continence of the patient postoperatively?”

(12): Gas incontinence 2 weeks post op and normal bowel movements afterwards. We will include this clarification point in the “surgical technique and post-op” section.

“Explain further why this lesion was left open and not simply advanced for closure since it was so low in the anal canal since there may be an increased risk of bleeding without closure?”

(13): The defect was left open due to the size of the lesion, lack of bleeding after cautery, and complications like abscess formation that I have seen in previous TEM cases after closing the defect.

“Please describe the pathology findings of the final specimen.”

(14): Detailed description of the pathology findings has been included in the “surgical technique and post-op” section.

“What further follow up is required for this patient and is there local or systemic recurrence risk?”

(15): The patient will have close follow-up every 6 months for surveillance of local recurrence. This is already included in the discussion.

(16): Format has been corrected per your suggestions.

(17): References and typesetting were corrected per the journal’s requirements. Since this is a very rare case, some studies we have reported are more than a decade old and hence do not have DOI numbers. I have looked at the “Revision policies of BPG for Case Report” document and found the following clause, “At least 1 reference should be included, covering important publications cited in PubMed over the past four years. For key references, however, publication time is not strictly restricted.” I have went on line to the source recommended to find DOI but couldn’t do so for older references. Additionally, I recruited help from EndNote expert at our University and was unable to come up with DOI. Therefore, all references have PMID but only the very new ones also have a DOI. I apologize about this and we have tried our best to comply with the publication guidelines. Please let us know if you find another way to add DOIs.

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

Sincerely yours,

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