Format for ANSWERING REVIEWERS

February 10, 2013

Dear Editor,

Please find enclosed the edited manuscript in Word format (file name: 1122-revised.doc).

Title: Endoscopic transluminal pancreatic necrosectomy using self-expanding metal stent and high flow water jet system

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The manuscript has been revised according to the suggestions of reviewer:

1 Format has been updated and the language has been polished.

2 References and typesetting were corrected

3 Revision has been made according to the suggestions of the reviewer

Major points

1. The stomach might be worried about during the coming period of life of the patients for the permanent access for transgastric necrosectomy during 2-3 weeks.

The temporary placement of self-expanding metal stent (SEMS) results in a sustained open fistulous tract between the stomach and pancreatic necrotic cavity, through which the endoscopic transluminal necrosectomy (ETN) can be easily performed. The relatively short duration of SEMS in place prevents from stent related potential complications. To prevent the extreme endotoxin challenge of the gastrointestinal tract resultant from the removed debris we place a suction drain (naso-gastric tube) into the stomach and a naso-biliary catheter into the necrotic cavity. We believe that continuous lavage performed constantly together with suction may prevent from any stomach related discomfort. Patients receive enteral (jejunal) feeding during the period of ETN and furthermore, for about 6 weeks. The artificial transluminal fistula usually spontaneously closes within three months as referred in the results section. The closure is confirmed either by endoscopy or water-soluble contrast swallow examination. In our practice, we start with oral feeding after confirmation of closure.

2. How about 'long-term clinical success' in the end of discussion, there is no long-term follow-up in this study.

There is no long-term follow up in this study. We have followed the patients until complete healing of the pancreatic necrosis or abscess. At the end of the discussion section we conclude in general in accordance with the literature that the ETN is associated with good long-term clinical success.

Minor points:

1. Too many paragraphys in the discussion section.

According to the reviewers suggestion we have redrafted the discussion section and decreased the number of paragraphs.

2. What is the meaning of 'PCT'.

PCT is the abbreviation of procalcitonin. We have written it out in the manuscript in full and inserted the abbreviation in brackets.

3. Case 2 (FJ) has died 3 weeks, on the 37th day of intensive care treatment (in the results section). However, according to the timing for case 2 of materials and methods section that she was transferred to the ICU on the second day of administration and an endoscopic necrosectomy was performed on the day 20, she should died '18 days', but not '3 weeks', after endoscopic intervention and she only had one endoscopic management.

In details, FJ was admitted on 31.01.2010 to our department, the emergency endoscopic retrograde cholangiopancreatography (ERCP) was performed on the same day. She was transferred to the intensive care unit two days later (corrected in the manuscript) on 02.02.2010. The first necrosectomy (SEMS implantation) was performed on the day 20, on 19.02.2010. Furthermore two endoscopic necrosectomies were carried out (23.02.2010 and 25.02.2010). The patient died 20 days (corrected in the manuscript) after the first endoscopic intervention on 11.03.2010, the 38th day (corrected in the manuscript) of intensive care treatment.

Thank you for reviewing our manuscript and for your suggestions.
We hope that our answers are satisfying and the manuscript will be accepted for publishing in the *World Journal of Gastroenterology*.
Sincerely yours,

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