December 17, 2014

Editor
World Journal of Gastrointestinal Endoscopy

RE: **Manuscript #14898**
Manuscript title: Gastrointestinal bleeding from Dieulafoy's lesion: Clinical presentation, endoscopic findings, and endoscopic therapy
Manuscript authors: Borko Nojkov, M.D., Mitchell S, Cappell, M.D., Ph.D.

Dear Editor:

Enclosed please find the revised manuscript in Microsoft Word which has been revised entirely in accord with the reviewers' suggestions, as follows:

Reviewer # 00505481

1. Criticism: Might be some pictures could be taken off.

Response by authors: As suggested by the reviewer, Figure 1 has been deleted for publication. The other figures have been renumbered as Figures 1-4 instead of Figures 2-5.

2. Please note: We have tried to open the file of Comments to Authors via Dear Editor.docx but this file could not be opened. We suspect that this file is empty with no criticisms within this file.

Reviewer # 00503883

1. Comments To Authors Congratulations for your excellent job! I just have one consideration: in your article middle GI bleeding is characterized when located between the ligament of Treitz and the cecum. In most recent articles middle GI bleeding was characterized when origin was located between the papilla and the ileocecal valves (1,2). Hadithi M., Heine G.D., Jacobs M.A., Van Bodegraven A.A., Mulder C.J. (2006) A prospective study comparing video capsule endoscopy with double-balloon enteroscopy in patients with obscure gastrointestinal bleeding, Am J Gastroenterol 101:52–57. Raju G.S., Gerson L., Das A., Lewis B. (2007) American Gastroenterological Association (AGA) Institute medical position statement on obscure gastrointestinal bleeding, Gastroenterology 133:1694–1696.

Response by authors: As suggested by the reviewer, we have modified the definition of middle gastrointestinal bleeding on Page 4, Introduction, as follows:

CHANGE TO:
"but can also cause middle GI bleeding (defined as bleeding localized between the ampulla of Vater and the cecum[2]),[3]"

FROM:

"but can also cause middle GI bleeding (bleeding localized between the ligament of Treitz and the cecum),[2]"

We have also added the following reference (as reference #2) to document the definition of middle gastrointestinal bleeding:
2. **Raju GS**, Gerson L, Das A, Lewis B. American Gastroenterological Association (AGA) Institute medical position statement on obscure gastrointestinal bleeding. Gastroenterology 2007; **133**:1694–1696 [PMID: 17983811].

Reviewer # 00724450

1. Nojkov et al. presented a review of Dieulafoy's lesion that is a really uncommon but interesting disease. It is an important etiology of acute gastrointestinal (GI) bleeding and many times can confuse with the other etiologies and have some difficulties for the diagnosis. As these parameters this review has an important value for the literature and clinicians for the awareness of this lesion. The authors were well presented the literature, as for diagnosis, treatment. It can be accepted as a manuscript.

Response by authors: No changes required in response to this reviewer's comments.

Editor's Revisions

1. Add a Core Tip
Response by authors: The following Core Tip has been added;

Core Tip
Dieulafoy's lesion is an important cause of acute gastrointestinal bleeding. Dieulafoy's lesions maintain an abnormally large caliber despite their peripheral, submucosal, location. Dieulafoy's lesions typically present with severe, active, gastrointestinal bleeding. About 75% of lesions are located in the stomach, most commonly close to the gastroesophageal junction, but lesions can occur in duodenum and esophagus. Endoscopy is the first diagnostic test (70% diagnostic yield). Lesions typically appear at endoscopy as pigmented protuberances from exposed vessel stumps, with minimal surrounding erosions. Endoscopic therapy, including clips, sclerotherapy, argon plasma coagulation, thermocoagulation, or electrocoagulation, is the recommended initial therapy, with primary hemostasis achieved in nearly 90% of cases. Mortality of bleeding from this lesion is 9-13%.

2. Please put the reference numbers in square brackets in superscript before the end. Please check across the text.

Response by authors: As requested, all the numbers for reference citations have been placed in brackets in superscript.

3. Repeat with reference 9, please correct.

Response by authors: As requested, the duplicate reference has been deleted and all the numbers for the references and the reference citations have been corrected.

4. Repeat with reference 59, please correct.

Response by authors: As requested, the duplicate reference has been deleted and all the numbers for the references and the reference citations have been corrected.

5. Please mark the location of Figures 3B (revised to Figure 2B), 4B (revised to Figure 3B), 5B (revised to Figure 4B), and 5C (revised to Figure 4C).

Response by authors: As requested, Figures 3B, 4B, 5B, 5C (revised as Figures 2B, 3B, 4B, 4C) have been all cited in the text of the paper (page 16, bottom), by adding the following:
"Successful cases of hemostasis of bleeding Dieulafoy lesions using various modalities of endoscopic therapy are illustrated in Figures 2-4."

Other revisions

The manuscript references have all been modified to conform with the journal style.

We enclose two copies of the journal article:
Dieulafoyreviewrevisedwithfigures – showing the final version with figures ready for publication.
Dieulafoyreviewrevisedtracked – showing the final version with most of the revisions tracked to show the changes (lacks the figures).

Thank you for your interest in this manuscript. Please note that we will gladly perform any further revisions necessary for publication of this manuscript in this prestigious journal.

Warm regards,

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