

Format for ANSWERING REVIEWERS

August 19, 2015

Dear Editor,



Please find enclosed the edited manuscript in Word format (file name: 16199-review.doc).

Title: Xanthogranulomatous cholecystitis mimicking gallbladder carcinoma: an analysis of 42 cases

Author: Yi-Lei Deng, Nan-Sheng Cheng, Shui-Jun Zhang, Wen-Jie Ma, Anuj Shrestha, Fu-Yu Li, Long-Shuan Zhao

Name of Journal: *World Journal of Gastroenterology*

ESPS Manuscript NO: 16199

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

1 Format has been updated

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

We very much appreciate the careful reading of our manuscript and valuable suggestions of the reviewer. Thanks very much for your comment, which is great helpful to consummate our research.

- (1) In the text under Material and Methods the evaluation of intra-operative findings should be more specific.

Re: We strongly agree with your comment. According to your experiential advice, in revision, in the Materials and Methods section, in paragraph 2: we add that: "For each patient, intra-operative findings included inflammation of the gallbladder (atrophy, edema or gangrene), adhesions of the gallbladder to adjacent tissues, thickened gallbladder wall, gallstones, mass lesions, gallbladder internal fistula, enlarged regional lymph nodes and hepatic abscess should be observed and recorded. And then, the excised gallbladder was opened along its longitudinal axis and the mucosa was examined macroscopically."

- (2) In the section of Discussion the extent of increase of CEA and Ca 19,9 should be mentioned in the 2 groups of patients.

Re: We strongly agree with your comment. So in revision, in the Discussion section, in paragraph 2: we point out that: "Increased presence of tumor markers such as CEA and CA 199 should raised suspicions of GBC. Some studies showed that the increased CA199 level (>20U/ml) had 79.4% sensitivity and 79.2% specificity, and the increased CEA level (>4.0ng/ml) had 93% specific, but only 50% sensitive. However, the increased CA199 and CEA levels (76% and 14%, respectively) were also presented in 42 XGCs, which proved to be futile and of no clinical significance in the differential diagnosis of XGC from GBC."

- (3) The intra-operative FS analysis procedure should be more elucidated

Re: According to your experiential advice, in revision, in the Materials and Methods section, in paragraph 2: we point out that: "If malignancy was suspected, suspicious areas would be labeled by the silk suture and sent for a FS analysis. Briefly, frozen sections of 6-μm thickness were cut

using automated devices (Shandon Citadel 2000, Astmoor, UK). Subsequently, sections were stained with hematoxylin-eosin staining (HE staining), and the diagnosis should be made by experienced pathologists. Simultaneously the direct contact between surgeons and pathologists would also be established."

- (4) Details about misdiagnosed GBC should be added.

Re: According to your experiential advice, in revision, in the Materials and Methods section, in paragraph 1: we point out that: "From July 2008 to June 2014, a total of 142 cases with pathological diagnosis of XGC were reviewed at our hospital, among which 42 cases (24 men and 18 women; male-to-female ratio, 4:3; mean age 59.9 years, age range 38-86 years) were misdiagnosed as GBC mainly by the presence of the focal or diffuse thickening of the gallbladder wall, and/or the mass protruding into the lumen based on preoperative radiographs, and/or intra-operative findings. 38 cases underwent contrast enhanced abdominal computed tomography (CT), and 4 cases underwent magnetic resonance imaging (MRI)."

- (5) Recent publications should be included instead of older ones.

Re: In revision, in the References section. References have been fully updated, and recent publications have been included instead of older ones.

- (6) In Table 2 separation between CT and MRI findings is mandatory.

Re: Thanks your experiential advice. However, we think that it seemed to be more appropriate to integrate the characteristic MRI findings with CT findings in our study. In revision, in the Results section, in paragraph 2: we point out that: "CT or MRI findings in 42 patients were summarized in Table 2. Only 4 of 42 patients (9%) underwent MRI, and studies suggest that the morphological appearance of the GBC in MRI was similar to that obtained with CT, so it seemed to be more appropriate to integrate the characteristic MRI findings with CT findings."

- (7) Details about serious surgical complications should be mentioned.

Re: According to your experiential advice, in revision, in the in the Results section, in the last paragraph, we point out that: "Comparison between the two groups showed no statistical difference in the incidence rates of complications (21% vs 20%, $P > 0.05$). However, there was 1 common bile duct injury which underwent a primary repair and "T-tube" drainage, 1 duodenal injury repaired by omental patch and suture repair for the TC group, while there were no serious complication observed in the SC group."

- (8) Several grammatical errors should be corrected.

Re: We are terrible sorry for numerous errors of case and grammar in our paper. We have revised the manuscript based on your experiential advice item-by-item. And the English in the revised manuscript has been edited and improved by two English scholars.

3 References and typesetting were corrected

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

Sincerely yours,

