

EDITOR DECISION – Minor revision

Manuscript Review: Evaluation of novel slim biopsy forceps for diagnosis of biliary strictures: single-institutional study of consecutive 360 cases (with video)

June 8, 2017

Professor Damian Garcia-Olmo

Professor Stephen C Strom

Professor Andrzej S Tarnawski

Editor-in-Chief

World Journal of Gastroenterology

Dear Professor Dear Professor Damian Garcia-Olmo, Professor Stephen C Strom, and Professor Andrzej S Tarnawski

We are very grateful for the helpful comments and suggestions regarding our article mentioned above. We are also very pleased to have been given a chance to revise the manuscript. With this letter, we are resubmitting a revised version of our manuscript accompanied by a point-to-point response to the comments. The comments raised were very valuable for improving our paper. We hope that our revisions and responses meet your expectation and that the revised manuscript is now suitable for publication.

Number ID: 02948135

1.Remove figure 3 and b as they are not needed.

Answer:

We deleted Figure 3 and b according to Editor's comments, and changed the sentence in manuscript (P11) and Figure3 below.

(before)

Sufficient tissue samplings for a definitive diagnosis including mucosal cancer, invasive cancer, and/or IgG4-positive plasma cells below the bile duct epithelium can be obtained using this forceps (Figure 3).

(after)

Sufficient tissue samplings for a definitive diagnosis including mucosal cancer, invasive cancer below the bile duct epithelium can be obtained using this forceps (Figure 3).

(After)

Figure 3

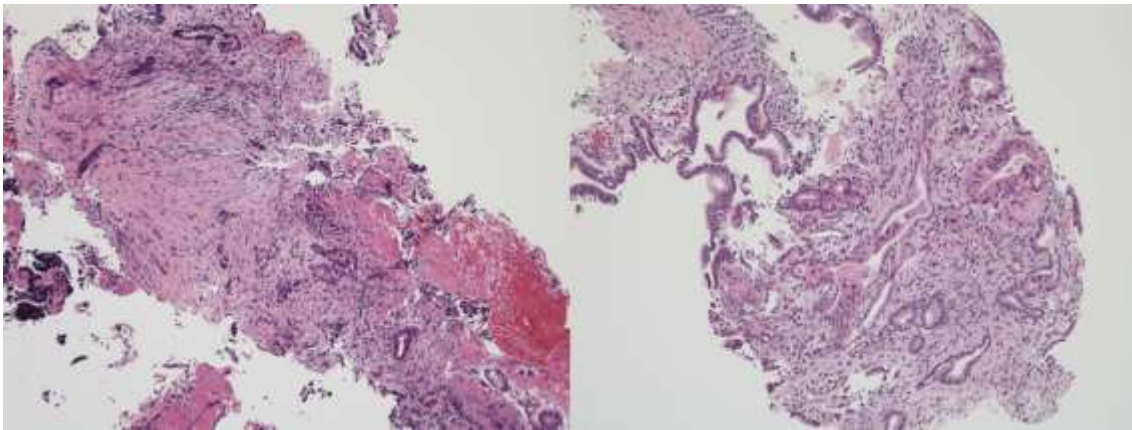


Figure 3 Biopsy specimens obtained using Radial Jaw 4P.

bile duct cancer (left) and pancreatic cancer (right) (H.E. stain, $\times 10$)

The biopsy specimen is sufficient and includes adenocarcinoma

2. Compare your finding to your historic series of using the ordinary forceps during ERCP. This will contrast the new forceps against your previous forceps.

Answer:

Thank you very much for a good comment. We wish we could compare the present data with historic series but we couldn't do that because of several reasons as follows: 1. Previously, we have used various transpapillary biopsy forceps, e.g. standard EGD forceps (small and standard), bending forceps, and ultraslim biopsy in the standard catheter, 2. Those forceps were used in non-consecutive cases, 3. There was no solid follow-up data in previous patients apart from current study. Thus, we are very sorry not to compare historic data with present data.

3. Please comment more on the experience of endoscopist who perform the biopsy, there are variations and I think endoscopist experience is one of the factors to influence sensitivity and specificity.

Answer:

We added the sentence according to Editor's comment below.

(Manuscript P6)

The obtained specimen was immediately fixed in 10% formalin. All procedures were performed by operators with experience in more than 100 ERCP cases per year.

4.Lots of repetitions in the text, please be concise.

We asked Native English Professor in our institution to edit the manuscript again.

5.What is your benchmark tests? AT YOUR INSTITUTION; what is the gold standard test to diagnose biliary cancer if biopsy [ERCP] fails to diagnose it?

Answer:

Thank you so much for important question. We basically decide final diagnosis regarding bile duct cancers with transabdominal ultrasound (TAUS), CT/MRI, EUS, cholangiopancreatography with or without intraductal US. If biliary strictures or filling defects are still indeterminate even by radiologic modalities, peroral cholangioscopy (visual impression) were performed for definite diagnosis.

Thus, we added the following sentence in P6 second paragraph.

Patients were excluded in the following cases: 1) prior histological confirmation of malignancy, 2) postoperative biliary strictures, 3) ampullary tumor, and 4) less than 6 months of follow-up in patients with negative malignant results. The final diagnosis was established by histopathological examination of tissues obtained endoscopically or surgically. If the histopathological diagnosis was negative for carcinoma, a clinical diagnosis was made from the clinical course for over 6 months or more and several radiological image findings from various imaging modalities such as TAUS, CT, MRI, MRCP, and endoscopic ultrasonography (EUS). If biopsy forceps was failed to diagnose and biliary strictures or filling defects were still indeterminate even by radiologic modalities, peroral cholangioscopy were performed for definite diagnosis.

Number ID: 02567669

The paper is well written, some minor language polishing might be possible.

Answer:

We asked Native English Professor in our institution to edit the manuscript again.

Number ID: 01213502

However, I am interested that how many of the studied patients having “long common channel” that are more common in the oriental population. In this situation, is it an easy procedure to do? Suggest the authors discuss more in this point of view.

Answer:

Thank you very much for an interesting comment. So called "long common channel" is divided into two categories, namely very long common channel like pancreatobiliary maljunction (PBM) and long common channel in normal anatomy. We have no experience of PBM in which transpapillary biopsy was needed. In terms of long common channel in normal anatomy, since we conventionally use wire-guided cannulation which is one of selective biliary cannulation without contrast injection, we don't know how many such cases we had. Anyhow, we perform the transpapillary biopsy after endoscopic sphincterotomy (EST) following wire-guided cannulation. Thus, regardless of existence of long common channel, insertion of biopsy forceps was not difficult after EST. However, since your comment is very interesting, we will check it prospectively from now on.

Number ID: 02510721

Answer:

Thank you very much for a good comment.

Number ID: 00053888

There are a number of grammatical errors that would benefit from correction but the study is worthy of publication.

Answer:

We asked Native English Professor in our institution to edit the manuscript again.