

## Format for ANSWERING REVIEWERS

June 24, 2013

Dear Editor,



Please find enclosed the edited manuscript in Word format (Resolution of an Esophageal Leak and Posterior Gastric Wall Necrosis with Esophageal Self-Expandable Metal Stents: 3918-review.doc).

**Title:** Resolution of an Esophageal Leak and Posterior Gastric Wall Necrosis with Esophageal Self-Expandable Metal Stents

**Author:** Majid A Almadi, Abdulrahman M Aljebreen, Fahad Bamihriz

**Name of Journal:** *World Journal of Gastroenterology*

**ESPS Manuscript NO:** 3918

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

(1) **Reviewer No. 1**

**- Reviewers comment**

The authors report an unusual complication following removal gastric banding and sleeve gastrectomy as oesophageal fistula associated with necrosis of gastric wall. This is an interesting case report, but the manuscript necessitated some explanation.

**- Response**

We thank the reviewer for his impression about the report and the effort to enhance the article content, we will respond to the reviewer's queries.

**- Reviewers comment**

1. On the abstract, the authors talk about anastomotic leaks but to my knowledge, there is no anatomosis during sleeve gastrectomy.

**- Response**

We have taken the reviewers suggestion into consideration, correctly so these should have been more properly called staple line leaks. We have changed that all throughout the report.

**- Reviewers comment**

2. There is few data concerning surgical procedure. Is the autors performed systematic methylene blue test after removal of gastric banding, after performed sleeve gastrectomy, or both? Why did they insert abdominal drains as systematic abdominal drainage is not recommended? (Albanopoulos K et al. Routine abdominal drains after laparoscopic sleeve gastrectomy: a retrospective review of 353 patients. *Obes Surg.* 2011"). And why did abdominal drainage was maintained 7 days ?

**- Response**

We share with the reviewer his concerns. Our center has been recognized for the management of complications after bariatric surgeries and thus this patient has been referred to our center from a private hospital after undergoing both these procedures as well as the diagnosis of the staple line leak not even realizing that the patient had a posterior gastric wall necrosis.

It is our practice to systematically perform the methylene blue test after LSG's. Our surgeons do not support the systematic use of abdominal drains and neither their prolonged use.

**- Reviewers comment**

3. Data used in the manuscript are old. There is two meta-analysis on gastric fistula rate after sleeve gastrectomy showing a gastric fistula rate of 2% ("Aurora AR et al. Sleeve gastrectomy and the risk of leak: a systematic analysis of 4,888 patients. Surg Endosc. 2012" and "Parikh M et al. Surgical strategies that may decrease leak after laparoscopic sleeve gastrectomy: a systematic review and meta-analysis of 9991 cases. Ann Surg. 2013").

**- Response**

We thank the reviewer for his effort, the only reason that we did not include these articles is that we were trying to limit the number of references used in this case report. Also we might argue that the reference that the reviewer was alluding to was in Clin Gastroenterol Hepatol 2012, which we think is a decent date given the time of submitting this report.

Given the reviewers suggestion we have added these references to the report.

**- Reviewers comment**

4. Also, the management of gastric fistula after LSG is not clear. In the discussion, the authors said that "Surgical management has been associated with a high morbidity (up to 50%) and mortality (2% to 10%)<sup>1</sup>, as a result, initial management has moved towards a more conservative endoscopic treatment.". Actually, it is recommended to perform revisional surgery in case of early onset gastric fistula then endoscopic treatment and firstline endoscopic treatment in case of delayed gastric fistula. First-line endoscopic management could be performed in this case because of presence of abdominal drains.

**- Response**

Although we agree with the reviewer in some of his statements, we think that in the case of leak management the option of treatment is a function of the presentation of the patient rather than only timing, we quote the following statement: "*Operative treatment in patients with staple line leak is mandatory when hemodynamic instability and peritonitis are present. In these cases, the operative treatment of leak recurrence is intended as "rescuing surgery." Peritoneal toilet and proper drainage are recommended. Reinterventions to simply repair the fistula have a high recurrence rate possibly because of the surrounding inflammatory tissue and high intraluminal pressure.*" Casella G, Soricelli E, Rizzello M, et al. Nonsurgical treatment of staple line leaks after laparoscopic sleeve gastrectomy. Obes Surg 2009;19:821-6.

Nonetheless, in this case we do agree that the management of this patient was adequately chosen to be endoscopic.

**- Reviewers comment**

5. data about SEMS treatment of fistula after sleeve gastrectomy presented here are not new and it is only a case report.

**- Response**

We agree with the reviewer that the data is not for the use of SEMS in staple line leaks but what is new is its use in the management of both a staple line leak as well as necrosis of the posterior gastric wall, thus we feel that this report does have an additive value to the literature.

3 References and typesetting were corrected

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

Sincerely yours,



Dr. Majid Abdularahman Almadi MBBS, FRCPC, MSc (Clinical Epidemiology)

Assistant Professor of Medicine

Division of Gastroenterology, King Khalid University Hospital

King Saud University

Riyadh, Saudi Arabia

Tel +966-1-4679167

Fax +966-1-4671217

e-mail: maalmadi@ksu.edu.sa

P.O. Box 2925(59)