

<Responses to the Editor's and Reviewer's Comments>

16<sup>th</sup> September, 2012

Dear Editor,

We have enclosed the edited manuscript in Word format.

**ESPS Manuscript No:** 399

**Manuscript title:**Biliary Phytobezoar Resulting in Intestinal Obstruction

**Author:**Yura Kim, Beom Jin Park, Min Ju Kim, Deuk Jae Sung, Dong-Sik Kim, Young-Dong Yu, JeongHyeon Lee

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

All changes are highlighted in the annotated manuscript.

All authors thank the editor and the reviewers for the valuable comments and helpful suggestions that contributed significantly to the revision of our manuscript.

< First Reviewer's comments>

**1. The term “phytobezoar” should be replaced by throughout the text with the simpler term bezoar.**

Response) We respect your comments. Hence, we have changed the word “phytobezoar” to “bezoar” throughout the manuscript, except in the introduction parts where we used “phytobezoar” for the definition descriptions.

**2. “We encountered a case of small bowel obstruction by a biliary phytobezoar. A biliary phytobezoar is a concretion of fibrinoid materials filling the extrahepatic bile duct. In the case reported here, the biliary phytobezoar in the extrahepatic bile duct migrated into the small bowel and resulted in complete intestinal obstruction.” This phrase should be removed since it duplicates data.**

Response) I agree with your comment.

Accordingly, I have shortened and modified the paragraph as follows. (2<sup>nd</sup> paragraph of introduction)

→We encountered a case of small bowel obstruction by a ‘biliary’ phytobezoar, which was formed in the extrahepatic bile duct and migrated into the small bowel resulting complete obstruction.

**3.The authors should discuss the Rigler’s criteria in paragraph 4 as well as the other radiological signs that distinguish a bezoar from a biliary stone (Rigler et al JAMA 1941) (LassandroetalAJR Am J Roentgenol 2005).**

Response) I agree with your recommendation, and therefore inserted sentences in the paragraph 4 explaining diagnostic points using Rigler’s criteria.

**4. The pathophysiologic mechanism of formation and migration a such a bezoar should be separately discussed (Papavramidis et al J Korean Med Sci 2009)**

Response) I respect your comment. However, based on previous studies and reports, the causes of the biliary bezoar formation is not clearly revealed and only the possible connection with the choledocho- or cholecystoduodenal fistula or diverticula in the walls of the bile ducts and duodenum are noted. This is written in 5<sup>th</sup> paragraph of the discussion section.

And for the migration/excistance mechanism of bezoar in small bowel, we have clarified in the 1<sup>st</sup> paragraph of introduction.

< Second Reviewer’s comments >

**1. A rare case presentation.**

**2. In the abstract instead of "mobilization" "migration" of the phytobezoar is a better word.**

Response) I respect your recommendation. I have changed the word accordingly.

**3. The conclusion that biliary phytobezoar should be considered as a DD for mechanical small bowel obstruction is not appropriate as this is such an exceedingly rare condition.**

Response) I agree with your comment. Therefore, I have modified the sentences as follows.

→Although it is considered extremely rare, biliary bezoar can be one of the possible causes of the mechanical small bowel obstruction in patients with the previously mentioned predisposing factors.

**4. References are not in a standard format. The journal names are in full. The total number also to be checked if not exceeding the limit for a case report.**

Response) Thank you for your kind comment. I have used “Endnote X5” version for the references and I used “World J Gastroenterology” format.

Some of the references lacked “DOI”s,hence I added them through [www.crossreference.org](http://www.crossreference.org). However, there were some references which didn’t have DOI and these were left only with the PMIDs.

Although, I have gone through the “Writing requirements of the case report” in the webpage of *World Journal of Gastroenterology*, I couldn’t find limitations of the numbers of the

references. However, if there are such regulations, please let me know and I will modify the manuscript accordingly.

## **5. The legend for the figures can be brief and to the point.**

Response) I respect your comment. I tried to shorten the sentences and removed some unnecessary words.

< Third Reviewer's comments >

### **1) Was the choledocal-duodenal fistula a natural (spontaneous) or post surgical (iatrogenic) fistula?..You have to specify this point! it is important!**

Response) It had been more than 10 years since the patient had cholecystectomy and it wasn't performed in our hospital. Because of such situation, there was no record of preoperative imaging findings nor surgical records. Hence, it is difficult to know whether the fistula existed ahead of the cholecystectomy.

However, as the reference in the discussion section, 2<sup>nd</sup> paragraph, 5<sup>th</sup> line, it is known that the choledoco-duodenal fistulas are usually formed after surgery. Therefore we can assume that the fistula in this patient was resulted from the prior cholecystectomy.

### **2) was a low or high volume fistula?**

Response) As you can see from the figure 1, (B) and (D), it was a slit like structure and therefore, can be said as a low volume fistula.

### **3) how did you treat CBD fistula during ERCP?; did you put inside the NBD only or did you place an endoscopic stent? if not, Why not?**

Response) By the time of ERCP, we only performed nasobiliary drainage as we mentioned in the first paragraph of the "Case report". Since it was only a slit like structure, we believed that this had little significance and therefore, no further treatment such as an endoscopic stent was performed.

### **4) did you perform biliary sphincterotomy in order drain the CBD?**

Response) No sphincterotomy was performed.

### **5) did you perform a large endoscopic sphincterotomy or not?**

Response) No, we did not perform endoscopic sphincterotomy. As we mentioned above, we did not perform any treatment related to the fistula.

**6)in your case...was the biliary fitobezoar secondary to choledochoduodenal fistula or due to endoscopic sphincterotomy if you performed it during therapeutic ERCP?**

Response) Since we did not perform sphincterotomy, we assume that the biliary phytobezoar in this patient was related to the choledochoduodenal fistula formation, resulted from previous history of cholecystectomy.

**7) after therapeutic ERCP, did the fistula close itself? ..if yes...how many time did the fistula need to close itself?...in the text we can read ..." aroutine MDCT checkup 6 months after discharge showed....the choledochoduodenal fistula was seen...so what do you mean? was the fistula open yet after 6 months of follow-up?**

Response) As I mentioned in the manuscript, we have performed follow up MDCT 6 months after the discharge. In that study, the choledochoduodenal fistula was still noted and it was visible in the regular follow up studies for 2 years since then without remarkable interval changes. Because the patient did not want to perform additional interventional procedure, we could not correct the fistula by therapeutic ERCP and surgery, and the fistula didn't close itself, too.

It is a great honor to have an opportunity to publish our manuscript in *World Journal of Gastroenterology*. I would like to thank editor and reviewers for the kind and respectable comments.

Sincerely yours,



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