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7901 Stoneridge Drive, Suite 501,
Pleasanton, CA 94588, USA
Telephone: +1-925-223-8242
Fax: +1-925-223-8243
E-mail: bpgoffice@wjgnet.com
https://www.wjgnet.com

Answering Reviewers

Name of journal: World Journal of Gastrointestinal Endoscopy

Manuscript NO: 41280

Title: Tight near-total corrosive strictures of proximal esophagus with contiguous involvement of hypopharynx: Flexible endoscopic management using a novel technique

Reviewer's code: 02444931

SPECIFIC COMMENTS TO AUTHORS

1. This article reported a novel flexible endoscopic technique for the management of tight near-total corrosive strictures of proximal esophagus with contiguous involvement of hypopharynx. While this is an interesting topic. 2. As a minimally invasive endoscopic management described in the Discussion part, there is no mention of different clinically treatments or other minimally invasive treatment for comparison.

Authors' reply: The other techniques for the management of such strictures include open surgical and rigid endoscopic techniques. In the revised document (6th and 7th paragraph of Discussion), we have added a description of these techniques as well. Furthermore (considering also the comments of the second reviewer), a new table (table 2) has been added to compare both these techniques with our technique.

3. When considering the prognosis conditions，the authors ignored to reflect the wound size, and what indicators used to determine the size of the wound after treatment.

Authors' reply: Please note that endoscopic wound size (after stricture dilatation) has never been discussed in the entire literature on endoscopic stricture dilatation (including the landmark papers on this topic published in prominent journals like Gastroenterology, Gut and GI Endoscopy). Wound size will approximately correspond to the stricture length but this is not of any practical significance. These wounds are internal and not

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externally visible; they will heal on their own with the passage of time. Rather more important are the complications (like perforation, bleeding, pain, re-stenosis etc) if they develop during or after the procedure. None of these problems occurred in our patients and this has been discussed in our article.

4. In the endoscopic procedure, there are some questions left behind: Is the co-axial diathermic dilator or other tools used to traverse new products? Is it used for the first time here? Isn't it smaller?

Authors' reply: The co-axial diathermic dilator is not a new product. As mentioned in the 2nd paragraph of Discussion, it has been previously used by other investigators as well. They used it in other parts of GI tract (antropyloric region, bile ducts and pancreatic ducts). However, we used it for the first time in the strictures of pharyngo-esophageal region.

Regarding the question "Isn't it smaller?" : No it is not smaller. As mentioned in the 2nd paragraph of Discussion, we used 10F size while other investigators used only 6F size. In fact, we used the largest available size (10F) of the diathermic dilator. Please note that the purpose of diathermic dilator is not to completely open up the stricture. Its only purpose is to slightly dilate the stricture so that the balloon dilator could be entered into it (for subsequent full dilatation of the stricture). As repeatedly mentioned in the article, the strictures in our patients were near-total (which means that they were so tight that only the wire was going through them and the balloon dilators were not going).

5. Although a free-hand incision or lacking of electroincision after dilatationis is easy to relapse, is there any complications during or after electroincision? Even if there are no complications in these two cases, how to avoid or prevent serious complications that may occur?

Authors' reply: As mentioned in the Results, there were no intra-procedural or post-procedural complications in our patients.

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Regarding how to prevent the complications: In the revised document, we have added 1 paragraph in the Methods (Last paragraph of Methods) and another paragraph in Discussion (5th paragraph of discussion) on how to avoid serious complications.

6. In Table 1，a comparison between the two cases and the traditional treatment methods could be added to make the advantages of the novel endoscopic technique more clearly.

Authors' reply: It was not technically possible to add into table 1 the information about traditional methods for comparison. This is because the information about most of the parameters which we assessed in table 1 is missing in the literature on Traditional methods. Furthermore, some of the parameters in table 1 are technique-specific and it won't be sensible to talk about those parameters for traditional techniques.

However, considering your viewpoint, we have added another table (table 2) to compare our technique with the traditional techniques, using various parameters which were comparable between the 3 techniques.

7. In the first half of Video 3, for the sake of explanation, the time of cutting was too long. The process of expansion, as well as the wire, was not shown in the video.

Authors reply: Actually, the main novelty of our technique is the sphincterotome-assisted electroincision, which has been demonstrated by the first part of video 3. **In fact, the first part of video 3 represents the crux of our paper.** We, all authors, strongly feel that this part of the video should not be truncated because in the truncated version, the readers won't be able to understand or learn the novel technique described by us. Hence, we have not modified this in our revised document. However, if the Science Editor or Company's Editor-in-Chief strongly feel to change the video, we will ensure this in the subsequent revision of our document.

Regarding "process of expansion and wire not shown in the video": Please note that it is technically not possible to show the wire in the endoscopic video; because the wire can only be shown in the fluoroscopic image. In fact, the main purpose of doing the

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procedure under the fluoroscopic guidance is the visualization of the wire (to ensure it is correctly placed). Similarly, the full balloon during expansion can only be shown fluoroscopically.

Hence we have shown the wire in image 2d and the proximal part of fully expanded balloon in image 2e and 3e, and complete part of the fully expanded balloon in image 2f.

8. There is some inconsistency in the page numbers of the reference format.

Authors' reply: This has been rectified.

9. Some English expression in the test may not be appropriate and some sentences are difficult to follow. For example: Line 93. Change "depriving the patients from life-saving minimally invasive therapy" by "depriving the patients of life-saving minimally invasive therapy". Lines 120-121. In the sentence: "Strictures in both the cases were felt undilatable as the balloon dilators could not open up the adhesions in post-cricoid space and in the blocked piriform sinus", what does "undilatable" mean? Line 160. "22 months in first case and 14 months in second case" should be "22 months in the first case and 14 months in the second case". Line 203. "repoted" should be "reported". Line 220. "cricipharyngeal" should be "cricopharyngeal". Line 275-276. "in one of the piriform sinus" should be "in one of the piriform sinuses".

Autors' reply: All these linguistic and grammatical mistakes have been corrected.

Undilatable (Un-dilat-able) means the strictures could not be dilated further (with the balloon dilator). The word "Undilatable" has also been previously used in the literature on stricture dilatation. Please see the articles by Ananthakrishna et al and Wu et al cited by our document (references 3 and 4 in the revised document)

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Reviewer's code: 01047575

SPECIFIC COMMENTS TO AUTHORS

This is a case report study which reported a novel treatment of tight near-total corrosive strictures of proximal esophagus with hypopharyngeal involvement. This is significant, especially for clinicians. However, the manuscript was not well prepared. 1.The characteristics of these two cases should be summarized well to guide the treatment of this disease and to answer some questions, such as what's the indication of this novel method?

Authors' reply: The characteristics of the patients have been summarized in the revised document (including table 1). The patients had tight pharyngo-esophageal strictures and intuitively, severe dysphagia was the indication of this novel technique. We have specified in the revision (under the section on Initial Management) that they presented to us with absolute dysphagia.

2.Generally speaking, treatments for the strictures of proximal esophagus includes many methods, such as surgery and endoscopic management. The authors should compare the advantages and disadvantages of this novel treatment with other methods.

Authors' reply: In the revised document (6th and 7th paragraph of Discussion) we have briefly discussed about the other 2 techniques (surgery and rigid endoscopy). Furthermore, a new table (table 2) has been added to compare both these techniques

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with our technique.

3.The abbreviation should be given the full spelling in the first presence.

Authors' reply: Okay. The required changes have been made.