

Rome, December 5<sup>th</sup>, 2018

## Response letter

Manuscript NO: **43063**

Vanella G, Coluccio C, Di Giulio E, Assisi D, Lapenta R. Tertiary stent-in-stent for obstructing colorectal cancer: a case report and literature review. *World J Gastroenterol* 2018. Revising.

Dear Editor,

We thank you for considering our work for publication and, above all, for your careful and meaningful suggestions, which helped us improving and clarifying parts of the manuscript.

First, we hereafter analytically answer the referees' comments.

Reviewer's code: 03261379

### COMMENTS TO AUTHORS

*Congratulations on your success in this case. There are a few modifications to be made: - please specify when exactly the therapy with Bevacizumab was introduced. - minor English review (mostly rephrasing). - please update the references*

### ANSWER

We thank Reviewer#1 for his positive opinion on our paper.

We also thank for the suggestion to point out in the manuscript when bevacizumab was added to chemotherapy schedule. We now report in the text that therapy with bevacizumab was introduced 18 months after the diagnosis (i.e. 12 months after the second SEMS-in-SEMS positioning and 4 months before the tertiary stenting).

Minor language polishing has been performed.

We also appreciated the opportunity to enrich our reference list (at the time of the initial submission references were recommended to be up to 10), which now contains more than 30 references, including some very recently published evidence on the topic.

Reviewer's code: 00503405

## COMMENTS TO AUTHORS

*I this case report a unique form of palliation of bowel obstruction is presented, namely in a patient with recurrent intra-stent tumor ingrowth the positioning of a third stent-in-stent was carried out successfully. The availability of bowel stenting is very important in case of CRC patients with colon obstruction, and this team showed us that performing in-stent restenting may be a possible therapeutic option for patients suffering for inoperable CRC. I have only one technical question: why was not a relieving stoma performed in this patient? Because of the carcinosis?*

## ANSWER

We thank Reviewer#2 for the careful and positive opinion on our paper and on its clinical relevance. We thank also for the opportunity to clarify the reasons that led us to perform an endoscopic palliation, instead of a surgical one. We now report in the text that the main determinants of our choice were the presence of carcinosis and ascites complicating the disease along with the patient's willingness to avoid a stoma. These reasons, along with the availability of 24 hours surgical backup in our facility, led us to discuss with the patient the possibility of attempting a tertiary stent-in-stenting.

We further revised the manuscript following your kind suggestions and carefully referring to the updated versions of the guidelines for manuscript preparation, submission and revision for case reports.

- We are very grateful for the opportunity to add a short running title of 6 words focusing the topic of the paper and completing the title of the case
- We provided an audio core tip which we hope will attract readers to read the full-text article
- We provided all authors abbreviation names next to the manuscript title, as requested.
- We have clarified, in the case presentation, that the therapy with bevacizumab was introduced 18 months after the diagnosis (as requested by the Reviewer#1).
- We implemented the case report adding the solicited sections: "final diagnosis",

“treatment”, “outcome and follow-up”.

- In the “treatment” paragraph we specified the reason which led us to primarily consider the endoscopic palliation instead of the surgical option (as requested by the Reviewer#2).
- We have modified our Discussion providing also a brief conclusion with evidence-based recommendations. After the review of available literature, we compared the case with available evidence. Despite the procedure has never been described, we have tried to extrapolate the significance of the case in changing clinical practice and in driving further research on the topic, overcoming the limits of this case and exploring its reproducibility.
- We thank you for the opportunity to enrich our reference list (at the time of the initial submission references were recommended to be up to 10), which now contains 31 papers, including very recently published evidence.
- Figures will be submitted in separate files for the different panels of the same figure and a file name clearly identifying the figure and panel; a single figure legend for all panels of the same figures has been indicated in the text; we avoided layering directly over the figure, but figures containing arrows and other markers will be submitted in two versions: one with the markers and the other without, with an explanation of the labels in the figure legend.

We again thank you and the reviewers for your valuable suggestions and the opportunity to review our manuscript, which we wish you can consider worthy of publication on WJG.

We look forward to hearing from you.

With best wishes,

Yours sincerely,

Emilio Di Giulio, MD

*Associate Professor of Gastroenterology*

*Sapienza, University of Rome - Faculty of Medicine and Psychology*

*Head of Digestive Endoscopy Unit*

*Sant'Andrea Hospital*

Via di Grottarossa, 1035-1039 - 00189 Rome, Italy.

email: [emilio.digiulio@uniroma1.it](mailto:emilio.digiulio@uniroma1.it)

telephone: +39.06.33776151 - fax: +39.06.33776922