

PEER-REVIEW REPORT

Name of journal: World Journal of Gastrointestinal Endoscopy

Manuscript NO: 49758

Title: Secondary Angiodysplasia-associated Gastrointestinal Bleeding in End-Stage Renal Disease: Results from the Nationwide Inpatient Sample

Reviewer's code: 03706560

Reviewer's country: United States

Science editor: Jin-Lei Wang

Reviewer accepted review: 2019-06-19 12:13

Reviewer performed review: 2019-06-20 17:50

Review time: 1 Day and 5 Hours

SCIENTIFIC QUALITY	LANGUAGE QUALITY	CONCLUSION	PEER-REVIEWER STATEMENTS
<input type="checkbox"/> Grade A: Excellent	<input type="checkbox"/> Grade A: Priority publishing	<input type="checkbox"/> Accept	Peer-Review:
<input type="checkbox"/> Grade B: Very good	<input checked="" type="checkbox"/> Grade B: Minor language	(High priority)	<input checked="" type="checkbox"/> Anonymous
<input checked="" type="checkbox"/> Grade C: Good	polishing	<input type="checkbox"/> Accept	<input type="checkbox"/> Onymous
<input type="checkbox"/> Grade D: Fair	<input type="checkbox"/> Grade C: A great deal of	(General priority)	Peer-reviewer's expertise on the
<input type="checkbox"/> Grade E: Do not	language polishing	<input type="checkbox"/> Minor revision	topic of the manuscript:
publish	<input type="checkbox"/> Grade D: Rejection	<input checked="" type="checkbox"/> Major revision	<input type="checkbox"/> Advanced
		<input type="checkbox"/> Rejection	<input checked="" type="checkbox"/> General
			<input type="checkbox"/> No expertise
			Conflicts-of-Interest:
			<input type="checkbox"/> Yes
			<input checked="" type="checkbox"/> No

SPECIFIC COMMENTS TO AUTHORS

Thank you for the opportunity to review your study. This is an interesting study. My major concern is is that the database was evaluated from 2009 to 2014? Why not included patients from 2014 to 2019? The paper appears to be wrote 5 years ago based on methods and references. I also have several minor concerns that I think you improve your study as



**Baishideng
Publishing
Group**

7041 Koll Center Parkway, Suite
160, Pleasanton, CA 94566, USA
Telephone: +1-925-223-8242
Fax: +1-925-223-8243
E-mail: bpgoffice@wjgnet.com
https://www.wjgnet.com

you see below: Abstract: - The Nationwide Inpatient Sample database from 2009 to 2014
-Why you did not include patients in the last 5 years?

Reply: The Nationwide Inpatient Sample (NIS) used ICD-9-CM codes till September 2015. In the last quarter of 2015, from October 1, 2015, the NIS database transitioned to ICD-10-CM codes). Because of the transition from ICD-9-CM codes to ICD-10-CM codes, the database file structure for 2015, differs from the annual data files for other data years. The difference in data file structure for 2015, makes it difficult to accurately match datasets, apply clustering and weights in data files using ICD-9-CM codes till September 2015, to data files using ICD-10-CM codes starting October 1, 2015. To keep the study clean we analyzed datasets till 2014, like most other studies using NIS.

It takes some time to gather data nationally from all the States in US and compile it together to produce national datasets and make it available to researchers. Hence, there is a lag time and the latest NIS dataset available is till 2016, so we have only missed 2 years of NIS datasets (2015 and 2016) in the current analysis because of the change in structure of 2015 dataset, in transition of ICD-9 codes to ICD-10 codes.- please add more key words. Select mesh terms such as “gastrointestinal”, “renal”., “hemorrhage”.

Mesh terms key words included as suggested.

Core tip: Do not use just abbreviations without describe what it means before. For example: End-stage renal disease (ESRD) and gastrointestinal (GI).

Abbreviations removed in core tip. Abbreviations are used in the main text of manuscript after explaining what it means when used in first instance.

Introduction: - from 1996 to 2003: please search a more recent data.

Most recent data from the US Renal Data System 2018 Annual Data Report added.

- add new references with references 5-7, for example: Brito HP, Ribeiro IB, de Moura DTH, et al. Video capsule endoscopy vs double-balloon enteroscopy in the diagnosis of small bowel bleeding: A systematic review and meta-analysis. World J Gastrointest Endosc.

2018 Dec 16;10(12):400-421.

- wireless capsule endoscopy change for video capsule endoscopy

New references added as suggested:

Brito HP, Ribeiro IB, de Moura DTH, Bernardo WM, Chaves DM, Kuga R, et al. Video capsule endoscopy vs double-balloon enteroscopy in the diagnosis of small bowel bleeding: A systematic review and meta-analysis. World J Gastrointest Endosc. 2018 Dec; **10**:400-421. [PMID: 30631404 DOI: 10.4253/wjge.v10.i12.400]

Sakai E, Ohata K, Nakajima A, Matsushashi N. Diagnosis and therapeutic strategies for small bowel vascular lesions. World J Gastroenterol. 2019 Jun 14;**25**:2720-2733. [PMID: 31235995 DOI: 10.3748/wjg.v25.i22.2720]

-Material and Methods - This retrospective study utilized the Nationwide Inpatient Sample (NIS), 2009 to 2014. – why not 2019 or at least 2018?

The latest dataset available for NIS is till 2016, and data from 2019 or 2018 is not available.

- This retrospective study utilized the Nationwide Inpatient Sample (NIS), 2009 to 2014 [12,13] -References 12,13 do not appears to be accurate.

References 12, 13 have been corrected. Thank you.

- These missing data points were either analyzed as their own “Unknown” group or were grouped with the “Other” group, whatever was most appropriate. – please explain this information in details.

A small number of patients that had missing data for a given variable (e.g. primary payor) were grouped into a category called ‘Others/Unknown.’

To explain, the columns below are taken from Table 1 of the study:

Primary Payor	ESRD Discharges (n = 5,505,252)
Self-Payor	86,637 (1.58%)
Private Payor	606,394 (11.01%)

Medicaid	595,160 (10.81%)
Medicare	4,114,876 (74.74%)
Others/Unknown	102,185 (1.86%)

Of a total of 5,505,252 patients with ESRD hospitalizations only 102,185 (1.86%) had unknown status of primary payor and these patents were grouped into an Others/Unknown category so that we do not lose data for other variables.

Results: - please correct: United Sates to United States

Thank you. It has been corrected.

- Table 2: what REF means? – please include label

REF was abbreviation for Reference. It has been changed to reference in Table 2.

- supplementary table: AIDS is accurate or you mean HIV+?

AIDS is accurate

Discussion: In general the discussion is great. I made few comments below:

- Our study showed that over a 5-year period from 2009-2014, 5,505,252 patients were hospitalizations with the diagnoses of end-stage – needs English review.

The edits have been made. Thank you.

- use GI besides gastrointestinal.

Done.

- you do not need to say Marwan et al 2 x.

Corrected to using it only once.

- please comment on these findings: Medicare had the highest rate of Angiodysplasia associated-GI bleeding (0.50% of ESRD hospitalizations) and Self-Pay hospitalizations had significantly lower odds of Angiodysplasia associated-GI bleeding (OR: 0.32; 95% CI: 0.20, 0.51; P<0.0001) than Medicare patients. – include your comment on discussion section.

Medicare patients had the highest rate of Angiodysplasia associated-GI bleeding (0.50% of ESRD hospitalizations) shown in 2nd column highlighted in yellow from Table 1.

Primary Payor	End-stage renal disease hospitalizations	ESRD End-stage renal disease with Angiodysplasia associated-gastrointestinal GI bleeding	End-stage renal disease without Angiodysplasia
Self-Payor	86,637 (1.58%)	78 (0.09%)	86,559 (99.91%)
Private Payor	606,394 (11.01%)	2,114 (0.35%)	604,280 (99.65%)
Medicaid	595,160 (10.81%)	1,528 (0.26%)	593,632 (99.74%)
Medicare	4,114,876 (74.74%)	20,728 (0.50%)	4,094,148 (99.50%)
Others/Unknown	102,185 (1.86%)	261 (0.26%)	101,924 (99.74%)

Self-Pay hospitalizations had significantly lower odds of Angiodysplasia associated-GI bleeding (OR: 0.32; 95% CI: 0.20, 0.51; $P < 0.0001$) than Medicare patients. This is shown below highlighted in second column from Table 2, where Medicare is the reference. The inference is that Self-payor hospitalizations have 0.32 times lesser odds of Angiodysplasia associated-GI bleeding compared to Medicare hospitalizations.

Primary Payor		
Others/Unknown	0.69 (0.52, 0.90)	0.0072
Medicaid	0.84 (0.69, 1.01)	0.0669
Private Payor	0.96 (0.83, 1.10)	0.5551
Self-Payor	0.32 (0.20, 0.51)	< 0.0001
Medicare	Reference	

References: References are very old. You just have 2 references after 2016.

Not much work has been done on Angiodysplasia associated Gastrointestinal bleeding in



**Baishideng
Publishing
Group**

7041 Koll Center Parkway, Suite
160, Pleasanton, CA 94566, USA
Telephone: +1-925-223-8242
Fax: +1-925-223-8243
E-mail: bpgoffice@wjgnet.com
https://www.wjgnet.com

renal disease and hence there were not many new references. I have updated and included newer references which now include 6 references from 2017-2019.

Looking forward for your answers. Thank you.

INITIAL REVIEW OF THE MANUSCRIPT

Google Search:

- ☐ The same title
- ☐ Duplicate publication
- ☐ Plagiarism
- ☐ No

BPG Search:

- ☐ The same title
- ☐ Duplicate publication
- ☐ Plagiarism
- ☐ No

PEER-REVIEW REPORT

Name of journal: World Journal of Gastrointestinal Endoscopy

Manuscript NO: 49758

Title: Secondary Angiodysplasia-associated Gastrointestinal Bleeding in End-Stage Renal Disease: Results from the Nationwide Inpatient Sample

Reviewer's code: 03026750

Reviewer's country: Egypt

Science editor: Jin-Lei Wang

Reviewer accepted review: 2019-06-19 09:36

Reviewer performed review: 2019-06-25 16:48

Review time: 6 Days and 7 Hours

SCIENTIFIC QUALITY	LANGUAGE QUALITY	CONCLUSION	PEER-REVIEWER STATEMENTS
<input type="checkbox"/> Grade A: Excellent	<input type="checkbox"/> Grade A: Priority publishing	<input type="checkbox"/> Accept	Peer-Review:
<input type="checkbox"/> Grade B: Very good	<input checked="" type="checkbox"/> Grade B: Minor language	(High priority)	<input checked="" type="checkbox"/> Anonymous
<input checked="" type="checkbox"/> Grade C: Good	polishing	<input type="checkbox"/> Accept	<input type="checkbox"/> Onymous
<input type="checkbox"/> Grade D: Fair	<input type="checkbox"/> Grade C: A great deal of	(General priority)	Peer-reviewer's expertise on the
<input type="checkbox"/> Grade E: Do not	language polishing	<input type="checkbox"/> Minor revision	topic of the manuscript:
publish	<input type="checkbox"/> Grade D: Rejection	<input checked="" type="checkbox"/> Major revision	<input checked="" type="checkbox"/> Advanced
		<input type="checkbox"/> Rejection	<input type="checkbox"/> General
			<input type="checkbox"/> No expertise
			Conflicts-of-Interest:
			<input type="checkbox"/> Yes
			<input checked="" type="checkbox"/> No

SPECIFIC COMMENTS TO AUTHORS

Very important topic. However, I have some comments: 1. why was the study only from 2009 to 2014, why the last 5 years were not included?

The Nationwide Inpatient Sample (NIS) used ICD-9-CM codes till September 2015. In the last quarter of 2015, from October 1, 2015, the NIS database transitioned to ICD-10-CM

codes). Because of the transition from ICD-9-CM codes to ICD-10-CM codes, the database file structure for 2015, differs from the annual data files for other data years. The difference in data file structure for 2015, makes it difficult to accurately match datasets, apply clustering and weights in data files using ICD-9-CM codes till September 2015, to data files using ICD-10-CM codes starting October 1, 2015. To keep the study clean we analyzed datasets till 2014, like most other studies using NIS.

It takes some time to gather data nationally from all the States in US and compile it together to produce national datasets and make it available to researchers. Hence, there is a lag time and the latest NIS dataset available is till 2016, so we have only missed 2 years of NIS datasets (2015 and 2016) in the current analysis because of the change in structure of 2015 dataset, in transition of ICD-9 codes to ICD-10 codes.

2. The 4th paragraph in introduction you mentioned wireless capsule (Video capsule VCE) and also did not mention double balloon enteroscopy

double-balloon enteroscopy has been added to the 4th paragraph in Introduction, as suggested

3. If possible to describe the site, size and type of angiodysplasia in this patients

Since NIS is an administrative database, clinical and endoscopic findings are not possible and are limitations of the database.

INITIAL REVIEW OF THE MANUSCRIPT

Google Search:

- ☐ The same title
- ☐ Duplicate publication
- ☐ Plagiarism
- ☐ No

BPG Search:



**Baishideng
Publishing
Group**

7041 Koll Center Parkway, Suite
160, Pleasanton, CA 94566, USA

Telephone: +1-925-223-8242

Fax: +1-925-223-8243

E-mail: bpgoffice@wjgnet.com

<https://www.wjgnet.com>

- ☐ The same title
- ☐ Duplicate publication
- ☐ Plagiarism
- ☐ No