

December 18, 2013

Dear Editor,

Please find enclosed the edited manuscript in Word format (file name: 6020-Brief article.doc).

**Title:** Living-donor or deceased-donor liver transplantation for hepatic carcinoma: a case-matched comparison.

**Author:** Ping Wan, Jian-Jun Zhang, Qi-Gen Li, Ning Xu, Ming Zhang, Xiao-Song Chen, Long-Zhi Han, Qiang Xia

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

**ESPS Manuscript NO:** 6020

The manuscript has been improved according to the reviewer's and editor's suggestions (All the revisions have been highlighted in the updated version):

**1 Format has been updated according to editor's suggestions and "the revision policies of BPG for brief article"**

(1) Due to the word limit, the title has been revised as "living-donor or deceased-donor liver transplantation for hepatic carcinoma: a case-matched comparison".

(2) We have made use of a language editing service provided by a professional English language editing company (American Journal Experts), and the editorial certificate was attached.

(3) Figure format: I found that figures could not be edited even if it is in a word or ppt format, and they could only be edited in the SPSS software. Therefore, we have not revised the figures for the time being, but if there are any problems in the typesetting, please do not hesitate to contact us, we will do our best to cooperate.

(4) According to the new regulation for paper publication in our hospital, the appellation of our hospital should be expressed as "Ren Ji Hospital", not "Renji Hospital" any more, so the corresponding revision was made in the revised manuscript. Additionally, we added one more grant in the title page which has supported our study.

(5) Other revisions regarding the format of the manuscript have been made according to the editor's suggestion and the revision policies of BPG for brief article.

**2 Revision has been made according to the suggestions of the reviewer**

(1) **Comment:** The authors diagnosed HCC patients as with or within Milan criteria. The authors need to explain when and how diagnose HCC. (e.g. we diagnosed HCC one month before liver transplantation based on MDCT (Hitachi Medical.....))

**Response:** In the present study, data of oncological characteristics (tumor within or outside the Milan criteria, tumor size, tumor number, vascular invasion and tumor pathological type) were based on the intraoperative findings and confirmed pathologically after LT. According to your good suggestion, the statement above was added in the

section of MATERIALS AND METHODS (Page 7, Line 14)

(2) **Comment:** The authors focused on biliary complications after LDLT/DDLT, however, they did not mention how to undergo biliary reconstruction (duct-to duct anastomosis of biliaenteric anastomosis, contentious suture or intermitted suture). In addition, the authors should explain how to treat biliary complications.

**Response:** It is really true as you suggested. In order to explain this issue to the readers, we added the following part in the section of MATERIALS AND METHODS (Page 7, Line 29): Biliary tract reconstruction was performed using a duct-to-duct anastomosis. The posterior anastomosis line was sutured continuously with 7-0 Prolene, while an interrupted suture was applied to the anterior anastomosis line.

As for the diagnosis and treatment of biliary complications, the following two parts was added in the sections of MATERIALS and DISCUSSION:

(Page 8, Line 11) As for biliary complications, a bile leak was diagnosed through abdominal drains or reexploration findings, while an anastomotic stenosis was detected on the basis of an overt dilatation of the intrahepatic duct according to computed tomography or ultrasonography, or on the basis of direct visualization using endoscopic retrograde cholangio- pancreatography (ERCP).

(Page 15, Line 6) There were 5 bile leak cases in this study, all of them diagnosed within the first month, of whom 2 patients underwent reexploration. Continuous abdominal drainage was the most important treatment modality for bile leaks. Unlike bile leaks, the stenoses (10 out of 12 cases) were mostly detected in the outpatient clinic after worsening of liver function, symptoms of cholangitis, or intrahepatic duct dilatation on computed tomography scans or magnetic resonance cholangio- pancreatography (MRCP). However, they could be successfully controlled with placement of a biliary stent through ERCP in most cases.

(3) **Comment:** In Table 1, there was data regarding preoperative down-staging treatment. There data is interesting and it should be better to add the data of “how long patients had to wait before transplantation”.

**Response:** Considering your good suggestion, we added the following part into the section of DISCUSSION (Page 14, Line 20):

In the present study, the median preoperative waiting time for LT in the LDLT group was 14 days (range: 5 to 63 days), which was significantly less than the 45 days (range: 20 to 235 days) in the DDLT group.

(4) **Comment:** In the section of discussion (Page 13 line10), the authors described the importance of tumor progression during the period of waiting for graft liver. It's better to refer to the following articles: Chan SC, et al. Wait and Transplant for Stage 2 Hepatocellular Carcinoma With Deceased-Donor Liver Grafts. Transplantation. 2013 Aug 6 Mizuno S, et al. Prospective study on the outcome of patients with hepatocellular carcinoma registered for living donor liver transplantation: how long can they wait? Transplantation. 2010 Mar 27; 89(6):650-4.

**Response:** The two articles are good references for our work. According to your suggestion, we added the following parts into the section of DISCUSSION:

**(Page 14, Line 11)** Patients with HCC, now widely accepted as legitimate transplant candidates, require special consideration to achieve timely transplantation. The study by Mizuno et al<sup>[30]</sup> showed that the median period between the registration for LDLT and the occurrence of extrahepatic metastasis, macroscopic vascular invasion or rupture of HCC was 12.2 months (range: 3.8–32.9 months), indicating that the waiting period suitable for a liver transplant is quite limited for HCC patients. Many patients with hepatic carcinoma lose their chance of LT or die of tumor progression during the waiting period, whereas the waiting period has greatly shortened and survival greatly improved with the advent of LDLT<sup>[31]</sup>.

**(Page 14, Line 23)** However, LDLT can only be feasible when a suitable volunteer is available, even though it is in theory a good alternative to DDLT. In Hong Kong, the policy of a 6-month wait for cadaveric liver allocation benefits the HCC patients who have practically no chance of undergoing LDLT. These modifications of the cadaveric liver allocation policy could result in transplants for as many HCC patients as possible but would not deprive non-HCC patients of a fair chance of undergoing LT<sup>[32]</sup>.

**3 References and typesetting were corrected, and the order of references was updated.**

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

Sincerely yours,



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