

# Answering reviewers

Dear Reviewers and Editors,

I am very glad to hear that our manuscript has been conditionally accepted for publication. On behalf of all authors, I would like to express our sincere appreciation for your constructive comments and correspondence regarding our article entitled "Current status of treatment of pancreatic and peripancreatic collections of acute pancreatitis" (Manuscript No.63084).

I have made extensive modifications to our previous manuscript according to your professional suggestions. In the present "Answering Reviewers," I will use red text to detail the major changes that have been made in the manuscript to correct the main weaknesses identified by the reviews.

**Reviewer:** *The author must describe about adaptation and previous evaluation of EGF*

In the revised article, we added the details of the procedure, which clarify the previous evaluation of endoscopic gastric fenestration (EGF) with endoscopic ultrasound (EUS), and the adaption of the EGF would be that the walled-off necrosis (WON) adhered to the gastric wall. This modification is given in red text and bold font in the revised manuscript.

**Reviewer:** *This article is an excellent review of pancreatic and peripancreatic fluid collections in pancreatitis. Despite the relative extensiveness in reviewing the most critical issues, there are some missing subjects that Authors can outline for completeness. The Authors state "invasive intervention is rarely needed in the treatment of PPC of acute pancreatitis, only persistent symptomatic, continuously size-increasing, or complicated PPC should be considered as indications". In my opinion, in this sentence, it should also be stressed that surgery should be the preferred choice in patients with clinical suspicion of a cystic tumour of the pancreas. "followed by minimally invasive necrosectomy is the current standard treatment if there are indications" maybe you can better specify "by retroperitoneal approach (VARD) videoscopic assisted retroperitoneal debridement. Please specify better the role if any of pancreatic duct stent placement in association to pancreatic duct in pancreatic fluid collections in the attempt to promote the pancreatic anterograde flow. There is no mention of the possible role of interventional radiology in major bleeding complications in patients with WON. In the paragraph "Timing for minimally invasive intervention", please repeat the very important concept that acute abdominal compartment syndrome is a strong indication to minimally invasive surgery (VARD) The Authors mention the step up approach in relation to the PANTER study. Please specify with accuracy what is the step un approach (minimally invasive step up approach, the clinical setting, surgical or endoscopic , with the reference if possible to the algorithm first described by Hjalmar C. van Santvoor, NEJM N Engl J Med 2010; 362:1491-1502. Please provide an algorithm that can be suggested as the best possible tretment of pancreatic and peripancreatic fluid collections in*

*accord with your review. Some small typos such as "too asthenia" too astenic.*

**Company editor-in-chief:** *I have reviewed the Peer-Review Report, the full text of the manuscript, and the relevant ethics documents, all of which have met the basic publishing requirements of the World Journal of Gastrointestinal Surgery, and the manuscript is conditionally accepted. I have sent the manuscript to the author(s) for its revision according to the Peer-Review Report, Editorial Office's comments and the Criteria for Manuscript Revision by Authors. Before final acceptance, the author(s) must add a table/figure to the manuscript.*

1.Thanks again for your nice comments on our review.

2.We agree with the idea that cystic lesions of pancreatic should be invasive intervened if the noninvasive examinations could not confirm the diagnosis. Therefore, we added a sentence as follows:

"In addition, when it is difficult to distinguish the PPC from pancreatic cystic tumors through noninvasive examinations, those cystic lesions should be intervened by a surgical or endoscopic approach without delay to make a clear diagnosis, and then determine the appropriate management."

This modification is given in red text and bold font in the revised manuscript.

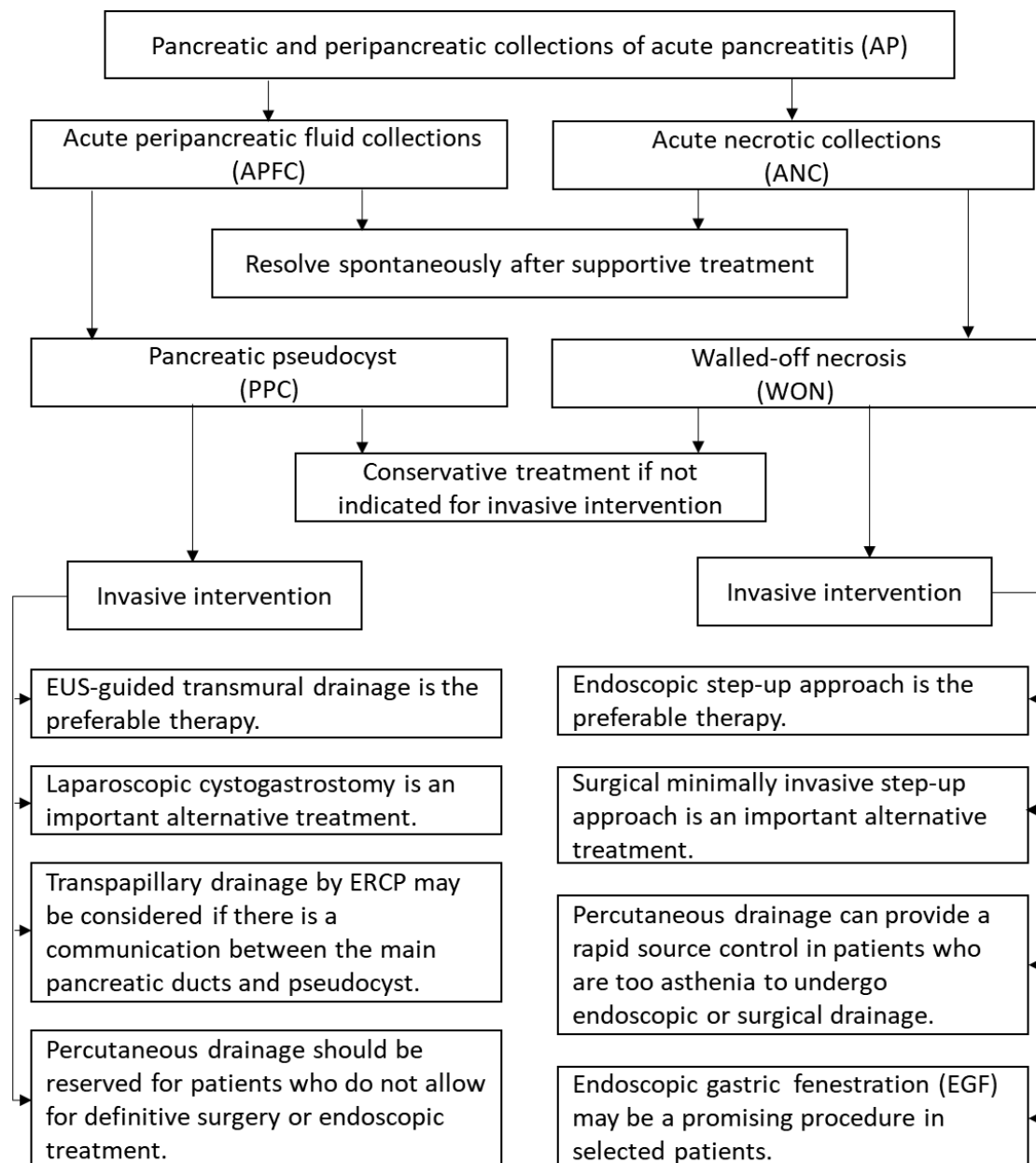
3.We have revised the "minimally invasive necrosectomy" to "video-assisted retroperitoneal debridement (VARD) or endoscopic necrosectomy" for a better explanation. This modification is given in red text and bold font in the revised manuscript.

4.We have stressed that "pseudoaneurysm bleeding, which is life-threatening and may require immediate interventional radiology-guided coil embolization or open surgery" in the "Endoscopic drainage and necrosectomy" section. This modification is given in red text and bold font in the revised manuscript.

5.We have stressed that "the abdominal compartment syndrome is a strong indication for intervening with a high mortality and delayed exposure to high intra-abdominal pressure may result in irreversible damage to organ function" in the "Indications" section and repeat this concept in "Timing for minimally invasive intervention" section.

6.The step-up approach can be done both with minimally invasive surgery or endoscopy. The minimally invasive step-up approach was introduced in the PANTER study which was defined as percutaneous (or endoscopic trans-gastric) drainage followed, if necessary, by VARD. This study focused to patients with confirmed or suspected infected pancreatic or peripancreatic necrosis, conclude that the minimally invasive step-up approach, as compared with open necrosectomy, reduced the rate of the composite endpoint of major complications or death. This excellent paper was cited as reference 45 in our review, and the "minimally invasive step-up approach" was used to replace "step-up approach" in suitable situations.

7.We have drawn an algorithm of the treatment of pancreatic and peripancreatic collections as follows:



8.We apologize for our careless spelling mistakes and thank you for your careful reading and kind reminders.

Thanks again for your valuable comments. Hopefully, we could have our article been published in your journal. If there have been any other corrections we could make, please feel free to contact me.

Yours faithfully

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