December 24, 2013

Dr. Su-Xin Gou
Dr. J. L. Wang
Editorial Office
World Journal of Gastrointestinal Endoscopy

RE: Letter of Point-by-point responses to criticisms for Manuscript #7386: Gastrointestinal endoscopy in the pregnant woman

Dear Dr. Wang:

Thank you for your careful review and thoughtful criticisms of our manuscript entitled, "Gastrointestinal Endoscopy in the pregnant woman" by Drs. David Friedel, Stavros Stavropoulos, Shahzad Iqbal, and Mitchell S. Cappell submitted as manuscript # 7386 to the World Journal of Gastrointestinal Endoscopy. We have thoroughly revised the manuscript according to the reviewers' criticisms as follows:

Reviewer #00504213

Author's response
No changes requested by this reviewer.

Reviewer #00504581
Comments: It would be interesting to shorten the writing in order to make easy to read it, considering the lack of scientific evidence in many of this topics. There are a lot of sentences in which the reader are not able to differentiate between author's opinions or author's suggestions or proposals coming from specific international guideline. I would like the author's try to distinguish them whenever be possible.

Author's response
As suggested, we have thoroughly revised the manuscript to describe the sources for the currently proposed recommendations on endoscopy during pregnancy as follows:

1. Page 3, Introduction.
CHANGE TO:
This work comprehensively, critically reviews the current data and literature on endoscopy during pregnancy; proposes recommendations on endoscopy during pregnancy based on the previously published American Society for Gastrointestinal Endoscopy (ASGE) guidelines (4) with modifications based on new data and consideration of previously unaddressed issues; analyzes how to modify procedures to promote maternal and fetal safety; recommends what to advise patients regarding fetal risks from endoscopy; and aims to stimulate new research in this field to resolve current ambiguities and controversies.
FROM:
This work comprehensively, critically reviews the current data and literature to guide clinicians on whether to perform endoscopy during pregnancy, how to modify procedures to promote

maternal and fetal safety, what to advise patients regarding fetal risks from endoscopy, and to stimulate new research in this field to resolve current ambiguities and controversies.

2. Page 10, Top paragraph.
CHANGE TO:
Sodium phosphate preparations have not been studied and should not be used during pregnancy. These current recommendations are stricter than the prior ASGE recommendations to use sodium phosphate "with caution" (4), because of occasional reports of electrolyte abnormalities and even renal failure associated with administration of these preparations to dehydrated nonpregnant patients (37,38).
FROM:
Sodium phosphate preparations have not been studied and should not be used during pregnancy. These preparations have been occasionally associated with electrolyte abnormalities and even renal failure when administered to dehydrated nonpregnant patients (37,38).

3. Page 11, Bottom.
CHANGE TO:
Colonoscopy should generally be avoided during pregnancy and be performed only when strongly indicated. Colonoscopy should be considered for the following strong indications: evaluation of a known colonic mass or stricture detected by radiologic examination; active, clinically significant lower GI bleeding; colonoscopic decompression of colonic pseudoobstruction; or other situations to avoid colonic surgery by colonoscopic therapy. These recommendations concur with the published ASGE guidelines (4), except for adding the last two new recommendations. Colonoscopy is not all-or-none and the colonoscopist encountering technical difficulty reaching the cecum or intraprocedural patient intolerance may reasonably abort the colonoscopy without reaching the cecum.
FROM:
Colonoscopy should generally be avoided during pregnancy and be performed only when strongly indicated. Colonoscopy should be considered for the following strong indications: evaluation of a known colonic mass or stricture detected by radiologic examination; active, clinically significant lower GI bleeding; colonoscopic decompression of colonic pseudoobstruction; or other situations to avoid colonic surgery by colonoscopic therapy. Colonoscopy is not all-or-none and the colonoscopist encountering technical difficulty reaching the cecum or intraprocedural patient intolerance may reasonably abort the colonoscopy without reaching the cecum.

4. Page 15. Middle.
CHANGE TO:
Strong indications for ERCP include choledocholithiasis complicated by jaundice, ascending cholangitis, or gallstone pancreatitis; and presentation with abnormal (cholestatic) liver function tests in a patient with gallstones and choledochal dilatation detected by abdominal ultrasound. These recommendations correspond with the published ASGE guidelines (4). ERCP should not be performed for weak indications, e.g. when therapy is unlikely at ERCP.
FROM:
Strong indications for ERCP include choledocholithiasis complicated by jaundice, ascending cholangitis, or gallstone pancreatitis; and presentation with abnormal (cholestatic) liver function

tests in a patient with gallstones and choledochal dilatation detected by abdominal ultrasound. ERCP should not be performed for weak indications, e.g. when ERCP therapy is unlikely.

5. Page 26. Table II, bottom.
ADD THE FOLLOWING:
FDA – United States Food & Drug Administration
*FDA categorizations of drug safety during pregnancy accepted as guidelines in the current report and by the American Society for Gastrointestinal Endoscopy (ASGE, [4]).
**This review does not recommend use of phosphate preparations during pregnancy. The ASGE recommends its use "with caution" (4).

6. Page 27-28, Table III, Bottom.
ADD THE FOLLOWING to the bottom of the Table:
*These recommendations incorporate the American Society for Gastrointestinal Endoscopy (ASGE) guidelines (4) as recommendations 1-4, & 7, but the current report adds recommendations 5,6 & 8 that were not addressed in the ASGE guidelines.

7. Page 30. Table V.
ADD THE FOLLOWING to the Bottom of the Table:
ERCP – endoscopic retrograde cholangiopancreatography, MRCP – magnetic resonance cholangiopancreatography, CBD – common bile duct
*These current recommendations incorporate the American Society for Gastrointestinal Endoscopy (ASGE) guidelines (4), as recommendations #1,2,5, & 7-10, but the current report adds recommendations #3 & 4 that were not addressed in the ASGE guidelines.

Editor's changes (Dr. S. X. Gou)
1. The affiliations of the authors have been changed to the required format for publication.

2. As required for publication, all references have been changed to bracketed numbers in superscript.

3. As required for publication, Figure 1 has been converted into TIFF format (in a separate electronic file) rather than being part of a Word document. A figure legend has been added for Figure 1.

Please note that we will gladly perform further revisions as required for publication of this manuscript in this prestigious journal. Thank you for your interest in this manuscript.

Warm regards,

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