

ESPS PEER-REVIEW REPORT

Name of journal: World Journal of Gastrointestinal Surgery

ESPS manuscript NO: 25636

Title: Total pancreatectomy: Short- and long-term outcomes at a high-volume pancreas center

Reviewer's code: 02445547

Reviewer's country: Singapore

Science editor: Shui Qiu

Date sent for review: 2016-03-20 12:13

Date reviewed: 2016-04-03 10:48

CLASSIFICATION	LANGUAGE EVALUATION	SCIENTIFIC MISCONDUCT	CONCLUSION
<input type="checkbox"/> Grade A: Excellent	<input type="checkbox"/> Grade A: Priority publishing	Google Search:	<input type="checkbox"/> Accept
<input type="checkbox"/> Grade B: Very good	<input checked="" type="checkbox"/> Grade B: Minor language polishing	<input type="checkbox"/> The same title	<input type="checkbox"/> High priority for publication
<input type="checkbox"/> Grade C: Good		<input type="checkbox"/> Duplicate publication	
<input checked="" type="checkbox"/> Grade D: Fair	<input type="checkbox"/> Grade C: A great deal of language polishing	<input type="checkbox"/> Plagiarism	<input type="checkbox"/> Rejection
<input type="checkbox"/> Grade E: Poor	<input type="checkbox"/> Grade D: Rejected	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Minor revision
		BPG Search:	<input checked="" type="checkbox"/> Major revision
		<input type="checkbox"/> The same title	
		<input type="checkbox"/> Duplicate publication	
		<input type="checkbox"/> Plagiarism	
		<input checked="" type="checkbox"/> No	

COMMENTS TO AUTHORS

Hi. 1. Clarify what is your definition of high volume centre and add this. 2. I completely disagree that any sound mind HPB surgeon would do TP during planned PD due to soft pancreas as claimed in introduction paragraph. It is criminal to certain extent. People in general modify technique or just do same technique BUT dont go to the extent of TP unless oncology demands. So erase that part. 3. I disagree that R2 resection for IPMN is OK. You quote your own paper and justify again! Cummon, do you believe this yourself? Is this based on sound evidence, if so what level and grade? Such bold statements will mislead weak readers of journals and they will start believing that R2 is ok. Do you want that message? 4. 40% vein resection for PD. How many histology were invasion seen in vein? We all know Prof Cameron experience about 95% desmoplasia and not invasion and resection is overdone. Whats your data and experience? 5. Do we need survival for benign disease? Is the cause of death relate to pancreas disease or other disease? 6. Why were IPMN operated? What is preop work up and what diagnostic criteria used? What management criteria used? 7. You mention 2008 onwards protocol is established. What is this protocol? We need readers to know that. 8. Unclear is



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any of your TP pts had auto islet transplant? 9. How do u manage enzyme replacement therapy? What is your protocol. Your paper needs this information. Op time blood loss Los morbidity etc is routine and honestly not of any value in a broad sense. Readers would want to know how do you manage perioperTively? 10. Tell readers about ICU stay, perioperative TPN use, transfusion needs and triggers, preoperTive optimization and assessment, adjuvant therPy protocols etc. 11. 90 day mortality of 6.8% and 1 year survival appx75%. What happens between 3 months to 1 year that 20% die? This is very intereting especially for benign pathology patients. This needs major discussion. 12. Define major glycemic event. 13. Why pt had hepatic insufficiency? 14. Clarify type of cardiac and pulmonary comorbidity? 15. Renal cell cancer, sarcoma etc cases TP wa done. Such cases need sepRTe discussion too. 16. Show only curvez of pdac and ipmn separately. 17. Is it right to assume that IPMN in patient with PDAC - PDAC came from IPMN? Can they not be coincidental? Whats evidence here. Thanks

ESPS PEER-REVIEW REPORT

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Title: Total pancreatectomy: Short- and long-term outcomes at a high-volume pancreas center

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CLASSIFICATION	LANGUAGE EVALUATION	SCIENTIFIC MISCONDUCT	CONCLUSION
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<input type="checkbox"/> Grade B: Very good	<input type="checkbox"/> Grade B: Minor language polishing	<input type="checkbox"/> The same title	<input type="checkbox"/> High priority for publication
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		<input type="checkbox"/> Plagiarism	
		<input type="checkbox"/> No	

COMMENTS TO AUTHORS

The paper describes the experience of total pancreatectomy from a single centre. Obviously, the staff and surgeons are very experienced, presenting excellent postoperative outcome and long-term survival. Although the results may seem encouraging, I am not convinced that it would be possible to repeat them in a broader setting. So far, pancreatic resection remains the treatment of choice as long as no studies have shown clear advantages in terms of survival from total pancreatectomy. There are some recent studies (e.g. Johnston et al, HPB 2016, 18, 21-28) that could be added to the references. Minor comments: In the results section, it is stated that there were no emergent TP for postoperative fistula. Do the authors mean that there were no postoperative fistulas following any of the 983 resections (in which case they should be congratulated for their results) or that they were excluded from the study group? Of the patients with PDAC, 20/42 had tumour recurrence. Within what time frame? If the recurrence were seen within the first 90 days mentioned in the methods section, would it not be better to perform a pancreas resection in order to spare the patients the side effects from a total pancreatectomy? Table 1 is, at first glance, slightly confusing. How many patients had PDAC



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as well as IPMN? How many had neither of them? What were the demographics for those who underwent open TP? Were there no patients with ASA I? Was islet autotransplantation considered for the 8 (or 14?) patients undergoing TP for benign causes?