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ESPS Peer-review Report

Name of Journal: World Journal of Clinical Cases

ESPS Manuscript NO: 2498

Title: Burr-hole evacuation for infratentorial subdural empyema

Reviewer code: 01212590

Science editor: Wang, Jin-Lei

Date sent for review: 2013-02-27 09:35

Date reviewed: 2013-05-09 07:07

CLASSIFICATION	LANGUAGE EVALUATION	RECOMMENDATION	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"/> Existed	<input type="checkbox"/> High priority for publication
<input checked="" type="checkbox"/> Grade C (Good)	<input type="checkbox"/> Grade C: a great deal of language polishing	<input type="checkbox"/> No records	<input type="checkbox"/> Rejection
<input type="checkbox"/> Grade D (Fair)	<input type="checkbox"/> Grade D: rejected	<input type="checkbox"/> Existed	<input checked="" type="checkbox"/> Minor revision
<input type="checkbox"/> Grade E (Poor)		<input type="checkbox"/> No records	<input type="checkbox"/> Major revision

COMMENTS TO AUTHORS

Was there a CT scan done prior to the initial LP. If not, this could be classified as negligent. LP - lumbar puncture should be changed to lumbar puncture. describe in detail what GCS 12 or 5 was - ie. the E?V?M?. this is helpful to give a good description of the patient.



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ESPS Peer-review Report

Name of Journal: World Journal of Clinical Cases

ESPS Manuscript NO: 2498

Title: Burr-hole evacuation for infratentorial subdural empyema

Reviewer code: 00722214

Science editor: Wang, Jin-Lei

Date sent for review: 2013-02-27 09:35

Date reviewed: 2013-05-14 18:51

CLASSIFICATION	LANGUAGE EVALUATION	RECOMMENDATION	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 type="checkbox"/> Grade B: minor language polishing	<input type="checkbox"/> Existed	<input type="checkbox"/> High priority for publication
<input type="checkbox"/> Grade C (Good)	<input type="checkbox"/> Grade C: a great deal of language polishing	<input type="checkbox"/> No records	<input type="checkbox"/> Rejection
<input type="checkbox"/> Grade D (Fair)	<input type="checkbox"/> Grade D: rejected	BPG Search:	<input type="checkbox"/> Minor revision
<input type="checkbox"/> Grade E (Poor)		<input type="checkbox"/> Existed	<input type="checkbox"/> Major revision
		<input type="checkbox"/> No records	

COMMENTS TO AUTHORS

The authors described a case of poster fossa subdural empyema (SDE) without extension to cerebello-pontine angle and cerebellar edema, who was successfully managed with burr hole evacuation. This is a worthy avenue in surgical neurology to move toward minimally invasive approaches. However, there is no defined rationale for why the authors think that this particular case may worth publishing. Burr hole evacuation of infratentorial SDE has been performed previously. There are several reports of various surgical approaches to posterior fossa SDE, ranging from single burr hole to extensive craniectomy.* Even conservative treatment with antibiotics has been described for some particular situations.** Also, needle aspiration has been used for SDE evacuations in infants.*** So, they did not describe a novel method. There are several vague aspects in the management of this patient, and some points should be considered in case presentation. First, no image of the first brain CT is presented. Though the authors stated that there was no space occupying lesion, it was better to enclose an image to be compared with the second CT. Also, it was not mentioned whether right mastoid cells opacity was observed in the first CT or not. Second, the lab data of the first day of admission and 10 days later would be better to be put into a table. Third, the way of managing hydrocephalus was so risky given that neither craniectomy nor ventricular drainage had been performed. In such a comatose patient with acute hydrocephalus - which is obvious in brain CT- it was wise to have a temporary CSF withdrawal system and taper it gradually, in particular when decompressive craniectomy had not been performed. The authors did not explain about the care and cautions they applied until complete improvement of CSF dynamic. Forth, the discussion and conclusion parts should give enough rationale for the authors' claim that their technique can be adapted as "first line" approach. It was better to say that it can be accepted as an



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“alternative” to other more invasive surgical approaches in certain situations. Fifth, the grammar and syntax in this submission are suboptimal. *Venkatesh MS, et al. Pediatric infratentorial subdural empyema: analysis of 14 cases J Neurosurg. 2006;105(5 Suppl):370-7. ** Taha MM, et al. Subtentorial subdural empyema: report of two cases and review of the literatures. Turk Neurosurg. 2011;21(4):669-73. ***Pathak A, et al. Controversies in the management of subdural empyema. A study of 41 cases with review of literature. Acta Neurochir (Wien). 1990;102(1-2):25-32.