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ESPS Peer-review Report
Name of Journal: World Journal of Gastroenterology
ESPS Manuscript NO: 7192
Title: Acute acalculous cholecystitis (AAC) immediately after gastric operation: a report of three cases and a review of literatures
Reviewer code: 00070192
Science editor: Ya-Juan Ma
Date sent for review: 2013-11-10 20:48
Date reviewed: 2013-12-07 18:58

CLASSIFICATION	LANGUAGE EVALUATION	RECOMMENDATION	CONCLUSION
[Y] Grade A (Excellent)	[Y] Grade A: Priority Publishing	Google Search:	[Y] Accept
[ ] Grade B (Very good)	[ ] Grade B: minor language polishing	[ ] Existed	[ ] High priority for publication
[ ] Grade C (Good)	[ ] Grade C: a great deal of language polishing	[ ] No records	
[ ] Grade D (Fair)		BPG Search:	[ ]Rejection
[ ] Grade E (Poor)	[ ] Grade D: rejected	[ ] Existed	[ ] Minor revision
		[ ] No records	[ ] Major revision

COMMENTS TO AUTHORS
The article is well written and it includes an interested topic. I suggest accepting the paper for publication without changes.

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Name of Journal: World Journal of Gastroenterology
ESPS Manuscript NO: 7192
Title: Acute acalculous cholecystitis (AAC) immediately after gastric operation: a report of three cases and a review of literatures
Reviewer code: 02732296
Science editor: Ya-Juan Ma
Date sent for review: 2013-11-10 20:48
Date reviewed: 2014-01-24 00:13

CLASSIFICATION	LANGUAGE EVALUATION	RECOMMENDATION	CONCLUSION
[ ] Grade A (Excellent)	[ ] Grade A: Priority Publishing	Google Search:	[ ] Accept
[ ] Grade B (Very good)	[ ] Grade B: minor language polishing	[ ] Existed	[ ] High priority for publication
[ ] Grade C (Good)	[Y] Grade C: a great deal of language polishing	[ ] No records	[ ]Rejection
[Y] Grade D (Fair)	[ ] Grade D: rejected	BPG Search:	[ ] Minor revision
[ ] Grade E (Poor)		[ ] Existed	[Y] Major revision
		[ ] No records	

COMMENTS TO AUTHORS
1. Introduction part, second paragraph first sentence: citation needed 2. Discussion part, third paragraph first sentence: citation needed 3. The indication for "abdominocentesis" for the Case 2 is unclear. Was it for diagnostic purposes? 4. Abbreviations should not be used before explanation. In the second sentence of Case 2, ASA abbreviation is used before its explanation. Explanation comes in the brackets. 5. Many major grammar, vocabulary and punctuation mistakes. A native English speaker's review is advised.

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ESPS Peer-review Report
Name of Journal: World Journal of Gastroenterology
ESPS Manuscript NO: 7192
Title: Acute acalculous cholecystitis (AAC) immediately after gastric operation: a report of three cases and a review of literatures
Reviewer code: 00535896
Science editor: Ya-Juan Ma
Date sent for review: 2013-11-10 20:48
Date reviewed: 2014-02-11 18:06

CLASSIFICATION	LANGUAGE EVALUATION	RECOMMENDATION	CONCLUSION
[ ] Grade A (Excellent)	[ ] Grade A: Priority Publishing	Google Search:	[ ] Accept
[ ] Grade B (Very good)	[Y] Grade B: minor language polishing	[ ] Existed	[ ] High priority for publication
[Y] Grade C (Good)	[ ] Grade C: a great deal of language polishing	[ ] No records	[ ]Rejection
[ ] Grade D (Fair)	[ ] Grade D: rejected	BPG Search:	[Y] Minor revision
[ ] Grade E (Poor)		[ ] Existed	[ ] Major revision
		[ ] No records	

COMMENTS TO AUTHORS

1.) The Introduction part could profit from a more precise presentation of the clinical picture, risk factors, etc. of the ACC. 5-10% of acute cholecystitis are acalculous and especially critically ill patients have a higher incidence to get an ACC. Patients after expansive abdominal surgical procedures like a gastric operation are predestinated to get such a complication, not only because having gastric surgery but e.g. having parental nutrition, suppressed immunity, vasoactive drugs. In addition gastric surgery seems to be a risk factor too. The role of ACC after gastric surgery in the literature is still debated. According to Wu [27] the extend of gastrectomy seems also to be an important factor in developing ACC. 2.) In the DISCUSSION part it is said: …"Furthermore, surgeons mostly intend to attribute this kind of abnormality to the previous surgery, so diagnosis can be delayed"… I think that diagnosis of ACC in critically ill patients often is delayed but patients after a surgery with a gastrointestinal anastomosis are profiting from e.g. CT- scan in time in order to exclude complications like leakage of the anastomosis. So these are the patients where the diagnosis of ACC is posed relatively rapidly. 3.) Percutaneous cholecystostomy can be performed safely in patients considered unfit for surgery. Outcomes are similar in patients with or without gallstones but most patients require subsequent definitive cholecystectomy. After cholecystostomy a 90% control of symptoms after 1 year is reported by some authors, for others cholecystostomy is only temporary solution to get the patient in a stable situation for performing the definitive cholecystectomy. There are also limitations in cholecystostomy regarding a gangrenous or perforated gallbladder. This should be discussed in the DISCUSSION part. 4.) In the DISCUSSION part it is

said: …"Importantly, the mortality rate of AAC after gastric surgery is very high (25% in this review)"… data of the literature is needed. The number of 25% after analyzing 3 patients is not adequate. 5.) A sum up or conclusion will be beneficial. E.g. after confirmation of the diagnosis ACC therapy has to be adopted according to patient's constitution. If there are no contraindications cholecystectomy combined with an antibiotic therapy should be performed. In cases of inoperability a cholecystostomy, percutaneous transhepatic gallbladder drainage or endoscopic transpapillary drainage are possible procedures. 6.) A revision of the manuscript by a native speaker is recommended.

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ESPS Peer-review Report
Name of Journal: World Journal of Gastroenterology
ESPS Manuscript NO: 7192
Title: Acute acalculous cholecystitis (AAC) immediately after gastric operation: a report of three cases and a review of literatures
Reviewer code: 02822992
Science editor: Ya-Juan Ma
Date sent for review: 2013-11-10 20:48
Date reviewed: 2014-02-18 07:05

CLASSIFICATION	LANGUAGE EVALUATION	RECOMMENDATION	CONCLUSION
[ ] Grade A (Excellent)	[ ] Grade A: Priority Publishing	Google Search:	[ ] Accept
[ ] Grade B (Very good)	[Y] Grade B: minor language polishing	[ ] Existed	[ ] High priority for publication
[ ] Grade C (Good)	[ ] Grade C: a great deal of language polishing	[ ] No records	[Y]Rejection
[ ] Grade D (Fair)	[ ] Grade D: rejected	BPG Search:	[ ] Minor revision
[Y] Grade E (Poor)		[ ] Existed	[ ] Major revision
		[ ] No records	

COMMENTS TO AUTHORS
The manuscript describes three cases of acute acalculous cholecystitis after gastric surgery. AAC can occur after any major operation or in patients with severe disease. This is not a new finding. In addition, the management with percutaneous cholecystostomy is the well established standard therapy. I personally was unable to find any information in the manuscript that would significantly add to the literature.

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Name of Journal: World Journal of Gastroenterology
ESPS Manuscript NO: 7192
Title: Acute acalculous cholecystitis (AAC) immediately after gastric operation: a report of three cases and a review of literatures
Reviewer code: 02440526
Science editor: Ya-Juan Ma
Date sent for review: 2013-11-10 20:48
Date reviewed: 2014-02-22 02:45

CLASSIFICATION	LANGUAGE EVALUATION	RECOMMENDATION	CONCLUSION
[ ] Grade A (Excellent)	[ ] Grade A: Priority Publishing	Google Search:	[ ] Accept
[ ] Grade B (Very good)	[ ] Grade B: minor language polishing	[ ] Existed	[ ] High priority for publication
[Y] Grade C (Good)	[Y] Grade C: a great deal of language polishing	[ ] No records	[ ]Rejection
[ ] Grade D (Fair)	[ ] Grade D: rejected	BPG Search:	[ ] Minor revision
[ ] Grade E (Poor)		[ ] Existed	[Y] Major revision
		[ ] No records	

COMMENTS TO AUTHORS
The article is a case series with review of literature about acalculous acute cholecystitis (AAC) after gastric surgery. Although the article is well structured, we suggest a few improvements. More attention is needed in abbreviations: in the introduction GI and GC are without explanation; in Case 2 ASA is used before its explanation; in the discussion AAC is substituted by ACC; MRI, WBC, CT, although well known, should be explained too. Introduction: epidemiology, risk factors, clinical characteristics, current diagnosis and therapy of AAC should be better and synthetically exposed. Discussion and review of literature: this paragraph could probably benefit of a structure in subparagraphs (literature search, epidemiology, diagnosis…). Especially the literature search methods could be improved by a better explanation of inclusion/exclusion criteria (how many articles did result from the first literature search? How many articles were not included and why?). A final paragraph called Conclusion is very important, in order to give the reader a clear "take home" message. A review by an English native speaker is needed.

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ESPS Peer-review Report
Name of Journal: World Journal of Gastroenterology
ESPS Manuscript NO: 7192
Title: Acute acalculous cholecystitis (AAC) immediately after gastric operation: a report of three cases and a review of literatures
Reviewer code: 00182191
Science editor: Ya-Juan Ma
Date sent for review: 2013-11-10 20:48
Date reviewed: 2014-02-24 21:45

CLASSIFICATION	LANGUAGE EVALUATION	RECOMMENDATION	CONCLUSION
[ ] Grade A (Excellent)	[ ] Grade A: Priority Publishing	Google Search:	[ ] Accept
[ ] Grade B (Very good)	[Y] Grade B: minor language polishing	[ ] Existed	[ ] High priority for publication
[Y] Grade C (Good)	[ ] Grade C: a great deal of language polishing	[ ] No records	[ ]Rejection
[ ] Grade D (Fair)	[ ] Grade D: rejected	BPG Search:	[Y] Minor revision
[ ] Grade E (Poor)		[ ] Existed	[ ] Major revision
		[ ] No records	

COMMENTS TO AUTHORS
This is a retrospective study (case series) on patients with acute acalculous cholecystitis. The authors present their experience with 3 patients suffering from this condition, their diagnostic strategy and the applied treatment. 1.Please explane when should perform an abdominosynthesis for the treatment of AAC 2.References number comes in the brackets and superscript. 3.All cases are presented detailed in the text. I think that th table 1 is not necessary. Please delete. 4.English grammar edition should give.

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Name of Journal: World Journal of Gastroenterology
ESPS Manuscript NO: 7192
Title: Acute acalculous cholecystitis (AAC) immediately after gastric operation: a report of three cases and a review of literatures
Reviewer code: 00042961
Science editor: Ya-Juan Ma
Date sent for review: 2013-11-10 20:48
Date reviewed: 2014-03-04 21:40

CLASSIFICATION	LANGUAGE EVALUATION	RECOMMENDATION	CONCLUSION
[ ] Grade A (Excellent)	[ ] Grade A: Priority Publishing	Google Search:	[Y] Accept
[ ] Grade B (Very good)	[Y] Grade B: minor language polishing	[ ] Existed	[ ] High priority for publication
[ ] Grade C (Good)	[ ] Grade C: a great deal of language polishing	[ ] No records	[ ]Rejection
[Y] Grade D (Fair)	[ ] Grade D: rejected	BPG Search:	[ ] Minor revision
[ ] Grade E (Poor)		[ ] Existed	[ ] Major revision
		[ ] No records	

COMMENTS TO AUTHORS

Case 1: Ten days after the operation the patient is febrile . Why is the patient treated empirically with antibiotics? It seems that at this post operatively time, an abdominal CT should be performed immediately to exclude a postoperative complication that is common after this type of surgery. Antibiotic treatment without performing additional tests does not seem to be appropriate at this post operative stage. An abdominal CT scan is performed at Day 13. But the diagnosed cholecystitis is very advanced and more serious for the patient. A new treatment with antibiotics alone is introduced ... until the patient is in septic shock. Why not be more aggressive earlier? The patient was considered operable for gastric cancer. He should be (early) considered operable for cholecystitis.
Case 2: This patient , although very fragile (Asa 3 , cerebral infraction, age 79) was considered operable . The tumor stage is T4 N2 (post resection). What was the evaluated preoperatively stage? It comes postoperatively with obvious signs of septic shock and a scanner that shows signs of cholecystitis and peritonitis. Again, why wait 24 hours before aggressive treatment? 24 hours of peritonitis in these fragile patients is often fatal. What realize an abdominocentesis in this condition ?
Case 3: One may question the indication to perform a cytoreductive surgery (and therefore non-curative) in a 72 years old patient with a tumor clinical stage T4 N + M1 (a gastro jejunal bypass in a symptomatic patient might be less invasive?). In this case, the diagnosis and treatment of cholecystitis was fast and efficient. The decision to perform percutaneous drainage seems appropriate in this situation. The patient showed no signs of septic shock and perform a cholecystectomy on the 37 th post operative day would have been very difficult. The discussion is

interesting. As mentioned by the authors, diagnosis and treatment are often delayed. The risk of gangrene is very high (40-80%) as well as mortality (25%). Early diagnosis and prompt treatment have resulted in a very good evolution of the case 3. Percutaneous gallbladder drainage is a treatment that can sometimes be effective, but data in the literature are insufficient. In case of calculous cholecystitis , such treatment should certainly be offered to inoperable patients. In case of acalculous cholecystitis after abdominal surgery, this treatment treatment may be proposed in patients without signs of septic shock. In cases of septic shock a surgical treatment is necessary. This surgical treatment can sometimes be achieved laparoscopically, even after a recent laparotomy . Although achieve cholecystectomy is not always possible, wash and drain the abdominal cavity largely be much more effective than percutaneous drainage. What can a radiological drain to treat gangrenous perforated cholecystitis with peritonitis? I think it is very difficult to give recommendation since there is not enough data in the literature. In this case, common sense is sometimes salutary. Early diagnosis and prompt treatment are essential in these patients weakened by their underlying disease and recent surgery.