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8226 Regency Drive, Pleasanton, CA 94588, USA
Telephone: +1-925-223-8242 Fax: +1-925-223-8243
E-mail: editorialoffice@wjgnet.com http://www.wjgnet.com

ESPS Peer-review Report
Name of Journal: World Journal of Gastroenterology
ESPS Manuscript NO: 7539
Title: Hepatitis B Vaccination in Patients with Inflammatory Bowel Disease (IBD)
Reviewer code: 00000085
Science editor: Yuan Qi
Date sent for review: 2013-11-24 15:27
Date reviewed: 2013-11-26 14:32

CLASSIFICATION	LANGUAGE EVALUATION	RECOMMENDATION	CONCLUSION
[ ] Grade A (Excellent)	[Y] Grade A: Priority Publishing	Google Search:	[ ] Accept
[ ] Grade B (Very good)	[ ] Grade B: minor language polishing	[ ] Existed	[Y] High priority for publication
[Y] 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 risk of HBV infection is increased in IBD patients due to immunosuppressive medications, other risk factors related to infection such as prior blood transfusions, surgery and endoscopy during the course of IBD. Those studies illustrate that all IBD patients should be screened by checking HBV serological markers prior to therapy with immunosuppressives on a routine basis, for this preventable disease. There is little to no information on HBV infection prevalence and the vaccination rate among IBD patients in the United States (US). This study is a retrospective, cross-sectional observational study. A retrospective chart review was performed in 500 patients who have been consecutively treated for (IBD) between September 2008 and January 2013 at the Rush University Medical Center Gastroenterology section (US). In this study, the authors found that less than half of IBD patients received the HBV vaccine. Additionally, gastroenterologists failed to order HBV serology in a significant majority of IBD patients. This suggests that gastroenterologists from the Rush University Medical Center may not be adequately educated and do not routinely recommend HBV screening and vaccination for their IBD patients on or off immunosuppressive agents. Major point This is an interesting paper that deserves to be published in WJG, however, the conclusions of the paper must only be limited to the practice of the Rush University Medical Center Gastroenterology section and not extend to the US. Additional studies have to be performed in order to extend these data to the US. Minor point The abstract is too long and must be reduced in length.

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ESPS Peer-review Report
Name of Journal: World Journal of Gastroenterology
ESPS Manuscript NO: 7539
Title: Hepatitis B Vaccination in Patients with Inflammatory Bowel Disease (IBD)
Reviewer code: 02567654
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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

Ascertainment of hepatitis B infection and immunity with subsequent treatment or vaccination has been recommended in several guidelines. However, the strength of evidence on which these recommendations are based is relatively weak. There is therefore critical need for observational studies that can highlight the magnitude of risk and/or the variability of practice in following guidelines. The authors have conducted an extensive and topical review of the practice pattern at their institution and highlighted the need for greater vigilance in screening within the IBD population. The article is in need of revision but likely without the need for extensive new analyses. 1.)Abstract length appears excessive and includes results of many sub-analyses; consider confining results to those regarding primary study aims 2.) The introduction would benefit from a brief summary of current screening and vaccination recommendations (sentence 1 from Discussion paragraph 3 could be moved here, for instance) 3.)Study design needs to carefully state how IBD cases were ascertained, was this through billing codes or ICD-9 codes, if so list the codes. 4.) Define "an HBV serology." Is there a standard panel in the Rush practice (there appears to be considerable variability in what was actually ordered (see below). 5.) In study design, formally define how prior infection, carrier status and prior vaccination were defined, especially by serology results (suggest CDC criteria: Centers for Disease Control and Prevention, Hepatitis B information for health professionals: Interpretation of hepatitis B serologic test results. Available from the CDC website.). 6.) In Results, Hepatitis B virus screening, of 220 who had "serology" checked there are variable denominators for what was ordered. HBsAg, anti-HBs-Ab and anti-HBcAb would be minimum required to identify IBD-relevant HBV disease states of current infection, past infection and immunity. In Discussion

highlight that the variation in orders may constitute evidence of variability in providers understanding of screening standards. Also, HBeAg would likely only be required/checked in a patient with a positive screen. Since this is a diagnostic/prognostic test, please consider removing this from results on screening practices. 7.) In Results, HBV vaccination according to age group, there is vague reasoning in the last sentence as to why younger patients would be more likely to be vaccinated; after moving this speculation to Discussion, consider adding references on CDC requirements for HBV vaccination in the age range of 0-18 in the general population (http://www.cdc.gov/mmwr/pdf/wk/mm62e0128.pdf). HBV is also required of many healthcare workers, college students, and military recruits (http://www.vaccines.mil/documents/371hbvaccination.pdf). 8.) Prevalence of HBV markers….should be combined with data on positive serology ("Hepatitis B virus screening") section of results. Table 3 should include racial/ethnic information of patient and or parents to determine if this was a risk factor (for instance, if all are from an endemic area like Africa or Asia, do we really need to screen all IBD patients?). 9.) Although obvious, it would improve clarity and speed for readers to include the HBV disease states of the patients in Table 3 (acute infection, chronic carrier, naturally immune). Patient 8 is likely a false positive HBeAg (unclear why this would ever have been checked without positives on other serologic tests, highlighting the need for practice standardization in test ordering). 10.) In Results, Comparisons of HBV prevalence…., please list the numbers positive and the number at risk for each study instead of percentages and re-cite the references. In Discussion, authors will need to clearly state that the study was in no way adequately powered to test single-digit percentage point differences in disease prevalence. Therefore, the statement "In this study, the prevalence of chronic HBV

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ESPS Peer-review Report
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[ ] 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	[ ]Rejection
[ ] Grade D (Fair)	[ ] Grade D: rejected	BPG Search:	[ ] Minor revision
[ ] Grade E (Poor)		[ ] Existed	[ ] Major revision
		[ ] No records	

COMMENTS TO AUTHORS
I think this is good study about physicians managing IBD patients should be aware of the need for screening and vaccination to prevent HBV infection or other infective disease and the guidelines for HBV screening and vaccination.

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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
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[ ] Grade E (Poor)		[ ] Existed	[Y] Major revision
		[ ] No records	

COMMENTS TO AUTHORS

I commend you for a very thorough paper. I have a few concerns: 1-the abstract results section and the introduction is quite verbose and can likely be cut down 2- you mention in the introduction there is little to no research - which is it? little or no? 3- you comment that guidelines recommend testing for hbv status at time of IBD diagnosis. You quote four references of which only one is a guideline from Dr. Sands, but you do not quote the guidelines from ACG. Regardless though, none of these guidelines specifically recommended testing for hbv status at time of diagnosis. Also, there is no standard of care to confirm a patient's vaccination status if they state they have been vaccinated especially if they can prove when they were vaccinated. There is no standard of care to actually check titers. While it makes sense to check titers if administered while immunosuppresed it doesn't make sense prior to using a biologic 4-you combine biologics and immunosuppresants. Only biologics require hep b status prior to initiation. Ideally in your results, and tables you should differentiate how many pts are on thiopurines vs biologics 5-when giving an example of an anti-tnf ideally you should list all of them so as not to imply infliximab is superior. 6-You do not tell us how many of your patients were seen by PCP's outside your EHR system as this would be very important in knowing how accurate some of the testing results are as patients may have been tested outside. You don't indicated if you read through all the notes to determine if a patient was tested outside your system 7-et al has a period after the al. 8-you don't describe your patients risk factors for hbv - i.e. ethnicity, ivdu history 9-what is the average or median duration of IBD disease? 10-in the results instead of mo for months you should probably just write months