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ESPS PEER REVIEW REPORT

Name of journal: World Journal of Gastroenterology
ESPS manuscript NO: 11873
Title: Sleeve-Wrapping of the Pedicled Omentum around Esophagogastric Anastomosis after Oesophagectomy for Preventing and Localizing Anastomosis Leakage
Reviewer code: 02546377
Science editor: Su-Xin Gou
Date sent for review: 2014-06-10 11:27
Date reviewed: 2014-06-11 21:05

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	[ ] Existing	[ ] 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		[ ] Existing	[ ] Major revision
		[ ] No records	

COMMENTS TO AUTHORS

This is a well-written and well scientific description of esophageal anastomotic techniques from a single institution over a relatively short time-frame. The methodology and results are clear and helpful. This paper performed an interesting method of anastomoses after oesophagectomy for squamous cell carcinoma of the thoracic oesophagus. The authors are to be congratulated on their excellent results.

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Reviewer code: 01047430
Science editor: Su-Xin Gou
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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	[ ] Existing	[ ] High priority for publication
[Y] Grade C: Good	[Y] Grade C: A great deal of language polishing	[ ] No records	
[ ] Grade D: Fair	[ ] Grade D: Rejected	BPG Search:	[ ] Rejection
[ ] Grade E: Poor		[ ] Existing	[ ] Minor revision
		[ ] No records	[Y] Major revision

COMMENTS TO AUTHORS

the technique is interesting and utilizes the protective properties of omentum flap as has been done in various other abdoinal surgeries in the past. My questions: Why do you not have a comparative control arm of patients who have undergone the conventional anastomotic technique? In its absence it is difficult to categorically conclude that the good results obtained are purely because of this innovation. what is the reason for using the anterior mediastinal route for gastric transposition? Lastly it well known that use of a circular stapler is associated with high anastomotic stricture rate; hence why this choice?

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Name of journal: World Journal of Gastroenterology
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Science editor: Su-Xin Gou
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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	[ ] Existing	[ ] High priority for publication
[ ] Grade C: Good	[ ] Grade C: A great deal of language polishing	[ ] No records	[Y] Rejection
[ ] Grade D: Fair	[Y] Grade D: Rejected	BPG Search:	[ ] Minor revision
[Y] Grade E: Poor		[ ] Existing	[ ] Major revision
		[ ] No records	

COMMENTS TO AUTHORS

? The English language used in this article proff is very poor. It can not be published in this form. ? Wrapping of the anastomosis does not necesarily prevent the development of a anastomotic fistula, but it can help block the fistula from the very beginning and thus lessen the clinical consequences of the fistula. It is debatable if the presence of the omentum brings enough growth factors and nutrients in the first 5-7 days after the operationt to really prevent development of a fistula. ? Wrapping the anastomosis with omentum is not really a new anastomotic technique, is just a supplimentary measure taken for a conventional technique ? Surgical technique: description of dissection of the esophagus is very poor, unintelegible while the use of English language is extremely innacurate. ? The gastric tube with a diameter of 3 cm predisposes to anastomotic fistula because a very narrow tube has difficulties in supplying good blood flow to the upper pole. Diameters of 4-6 cm are more likely to be associated with a lesser incidence in anastomotic fistula. ? The authors do not explain why do they bring the gastric tube in the chest using a route through the anterior mediastinum and not the orthotopic route. It is a rather unusual approach. ? The esogastric anastomosisi was performed in an end-to-end fashion using a circular stapler. How did the authors introduce the shaft of the circular stapler in the gastric tube to perform the T-T anastomosis? It very unclear how have they done that. ? How did the authors survey patients in the postoperativ period for development of a anastomotic fistula. There is no regular investigation for this purpose in a study that has

concentrated on prevention of anastomotic fistula. Were there any patients which had subclinical fistulas? In the only patient reported to have a fistula was there any clinical sign? Did the authors perform regular upper GI contrast studies to evaluate the anastomosis? ? How was the patient with fistula managed conservatively with enteral nutrition since there was no feeding jejunostomy placed at the end of the operation? ? The authors state that: "In our series of patients who are performed by the new technique after oesophagectomy, a lower leakage rate and quick recovery postoperatively were facilitated" but they do not explain which is their group of reference which had a higher anastomotic insufficiency rate ? The three measures the authors describe as innovative approach to the anastomosis are just examples of good surgical practice that should be employed in carefully done surgery. ? In esophageal cancers, the required margins are in the range of 10 cm due to the very rich submucosal vascular and lymphatic network, 5 cm may somethimes be to little, should be accompanyed by a frozen section.