

ESPS PEER-REVIEW REPORT

Name of journal: World Journal of Gastroenterology

ESPS manuscript NO: 14618

Title: Drainage strategy of unresectable malignant hilar biliary strictures by computed tomography volumetry

Reviewer's code: 00054001

Reviewer's country: Japan

Science editor: Jing Yu

Date sent for review: 2014-10-18 12:00

Date reviewed: 2014-10-28 17:02

CLASSIFICATION	LANGUAGE EVALUATION	SCIENTIFIC MISCONDUCT	CONCLUSION
<input type="checkbox"/> Grade A: Excellent	<input type="checkbox"/> Grade A: Priority publishing	PubMed Search:	<input type="checkbox"/> Accept
<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
<input type="checkbox"/> Grade C: Good	<input type="checkbox"/> Grade C: A great deal of language polishing	<input type="checkbox"/> Duplicate publication	<input type="checkbox"/> Rejection
<input type="checkbox"/> Grade D: Fair	<input type="checkbox"/> Grade D: Rejected	<input type="checkbox"/> Plagiarism	<input type="checkbox"/> Minor revision
<input type="checkbox"/> Grade E: Poor		[Y] No	<input type="checkbox"/> Major revision
		BPG Search:	
		<input type="checkbox"/> The same title	
		<input type="checkbox"/> Duplicate publication	
		<input type="checkbox"/> Plagiarism	
		[Y] No	

COMMENTS TO AUTHORS

I consider very interesting the authors' concept that how much minimal volume is required for successful biliary drainage when treating hilar biliary obstruction. However, authors' definition of successful drainage seems impractical for me. When treating obstructive jaundice, the goal of the treatment should be complete resolution of jaundice. Furthermore, if the cause of jaundice is malignancy, subsequent therapeutics, which might lead to survival benefit possibly bought on by the therapy, should be performed. Hence, primary endpoint should be resolution of jaundice and secondary endpoints should include whether subsequent antineoplastic therapy was given, patient survival, frequency and degree of cholangitis, and complications related to drainage procedures in this study. From these aspects, disease entities included in this study are too varied. Disease entity must be limited to hilar cholangiocarcinoma which is the commonest and most problematic cause of malignant biliary obstruction. Then, the authors must address the following issues. 1. Reason(s) for being unresectable: Many differences concerning drainage outcomes are present between cases with distant metastases and locally too advanced disease. 2. Authors' policy for biliary drainage caused by

unresectable hilar cholangiocarcinoma: I believe ordinary policy for this condition is “bilateral drainage”. In cases with possibly resectable disease, a policy is acceptable that planned resected area(s) is left undrain in order to promote functional shift to the future liver remnant. However, I consider that once determined to be unresectable, unilateral drainage is impractical and insincere unless technically difficult. 3. Evaluation for efficacy of stent(s) which was actually placed: It seems that the authors did not confirm the efficacy of stent(s) actually placed. If the placed stent(s) worked sufficiently, it can be confirmed by CT and/or US that dilatation of intrahepatic bile duct(s) is resolved in corresponding area(s). If not and jaundice is unresolved, additional drainage should be considered. I consider that required minimal volume must be calculated from post-procedural CT. 4. Clinical course of the study cohort: Related to the issues 2 and 3 above-stated, cases where single drainage is insufficient are often encountered and therefore plural attempts are needed in these cases. Authors should include summary of clinical courses of the study cohorts. The authors should radically reanalyze the data and rewrite the manuscript. And then I believe that this manuscript is worth being published.

ESPS PEER-REVIEW REPORT

Name of journal: World Journal of Gastroenterology

ESPS manuscript NO: 14618

Title: Drainage strategy of unresectable malignant hilar biliary strictures by computed tomography volumetry

Reviewer's code: 01804189

Reviewer's country: India

Science editor: Jing Yu

Date sent for review: 2014-10-18 12:00

Date reviewed: 2014-11-26 02:10

CLASSIFICATION	LANGUAGE EVALUATION	SCIENTIFIC MISCONDUCT	CONCLUSION
<input type="checkbox"/> Grade A: Excellent	<input type="checkbox"/> Grade A: Priority publishing	PubMed 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 checked="" type="checkbox"/> Minor revision
		BPG Search:	<input 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

Though it is a retrospective study but has clinical relevance. Patients of unresectable hilar blocks can be categorized into whether they require single or double stenting based on the status of liver function tests. Following questions should be addressed by authors: 1.why was stenting done in these patients of unresectable hilar blocks? were these patients having cholangitis or significant pruritis? or was stenting done just because of presence of jaundice? 2. According to this study all the patients were having compensated or decompensated cirrhosis how it is possible in all the cases. 3. What was the life expectancy of patients with decompensated cirrhosis with hilar block?do they really need Stent placement? 4.Majority of patients had Bismuth type3 or4 lesions and most of the patients were treated with plastic stents(it is not clear whether 7fr or 10fr) I think more patients will be harmed than benefited by this approach. 5. Authors should very clearly mention in their discussion about indications for stenting in hilar block and which stent (plastic or metallic) in which situation.

ESPS PEER-REVIEW REPORT

Name of journal: World Journal of Gastroenterology

ESPS manuscript NO: 14618

Title: Drainage strategy of unresectable malignant hilar biliary strictures by computed tomography volumetry

Reviewer's code: 00923968

Reviewer's country: China

Science editor: Jing Yu

Date sent for review: 2014-10-18 12:00

Date reviewed: 2014-11-19 11:41

CLASSIFICATION	LANGUAGE EVALUATION	SCIENTIFIC MISCONDUCT	CONCLUSION
<input type="checkbox"/> Grade A: Excellent	<input type="checkbox"/> Grade A: Priority publishing	PubMed 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 checked="" type="checkbox"/> Grade C: Good	<input type="checkbox"/> Grade C: A great deal of language polishing	<input type="checkbox"/> Duplicate publication	<input type="checkbox"/> Rejection
<input type="checkbox"/> Grade D: Fair	<input type="checkbox"/> Grade D: Rejected	<input type="checkbox"/> Plagiarism	<input type="checkbox"/> Minor revision
<input type="checkbox"/> Grade E: Poor		[Y] No	<input checked="" type="checkbox"/> Major revision
		BPG Search:	
		<input type="checkbox"/> The same title	
		<input type="checkbox"/> Duplicate publication	
		<input type="checkbox"/> Plagiarism	
		[Y] No	

COMMENTS TO AUTHORS

This is a retrospective study on 78 patients who underwent biliary drainage for unresectable malignant hilar biliary stricture. I have the following comments: (1) This is a relatively small study (n=78) on a very heterogeneous group of patients. The heterogeneities included the underlying pathologies, the drainage approach (percutaneous or endoscopic) and the type of stents used (nasobiliary drainage, metal stent or plastic stent). There are a lot of limitations in such a type of study. (2) It would be clearer to future potential readers to add the word biliary to the title of the paper making the title looks like "Biliary drainage strategy". (3) The authors stated "Drainage was considered effective when the serum bilirubin level decreased by $\geq 50\%$ of the value before stent placement within 2 weeks after drainage, without additional intervention". From previous studies, we know that the longer the history of obstructive jaundice is before drainage, the longer it takes for the liver to recover and the level of the bilirubin to drop. Did the authors study the duration of obstructive jaundice before drainage in this study group? If yes, did the duration has any impact on the effectiveness? (4) The authors stated in the Abstract "ROC analysis for effective drainage showed

cutoff values of 33% of liver volume for patients with preserved liver function (without decompensated liver cirrhosis) and 50% for patients with impaired liver function (with decompensated liver cirrhosis)". The authors also stated "Decompensated liver cirrhosis was defined as liver cirrhosis with ascites". As all the patients in this study had malignant obstructive jaundice, they all had deranged liver function. Furthermore, ascites can happen in patients with malignancy and not all patients who had cirrhosis had ascites. How did the author define decompensated liver cirrhosis in this study without a liver biopsy or at least a fibroscan? (5) It is surprising that the drainage procedures were successfully performed in all the 78 patients making a procedure success rate of 100%. During the study period, was there any patient who had all the inclusion criteria for this study who had an unsuccessful biliary drainage? (6) Early complications occurring within 7 days after biliary drainage were found in 14 patients. Did any of these complications cause a delay in the drop of bilirubin so that the bilirubin levels decreased by less than 50% of the value before biliary drainage within 2 weeks of the drainage? (7) According to the Brisbane 200 nomenclature of liver anatomy and resections (HPB 2000, 2(3):333-9), the term 'lobe' should be avoided.

ESPS PEER-REVIEW REPORT

Name of journal: World Journal of Gastroenterology

ESPS manuscript NO: 14618

Title: Drainage strategy of unresectable malignant hilar biliary strictures by computed tomography volumetry

Reviewer's code: 02954726

Reviewer's country: Japan

Science editor: Jing Yu

Date sent for review: 2014-10-18 12:00

Date reviewed: 2014-11-27 12:20

CLASSIFICATION	LANGUAGE EVALUATION	SCIENTIFIC MISCONDUCT	CONCLUSION
<input type="checkbox"/> Grade A: Excellent	<input type="checkbox"/> Grade A: Priority publishing	PubMed 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 checked="" type="checkbox"/> Grade C: Good	<input type="checkbox"/> Grade C: A great deal of language polishing	<input type="checkbox"/> Duplicate publication	<input type="checkbox"/> Rejection
<input type="checkbox"/> Grade D: Fair	<input type="checkbox"/> Grade D: Rejected	<input type="checkbox"/> Plagiarism	<input type="checkbox"/> Minor revision
<input type="checkbox"/> Grade E: Poor		[Y] No	<input type="checkbox"/> Major revision
		BPG Search:	
		<input type="checkbox"/> The same title	
		<input type="checkbox"/> Duplicate publication	
		<input type="checkbox"/> Plagiarism	
		[Y] No	

COMMENTS TO AUTHORS

The study addresses an important issue in the drainage strategy for treating malignant hilar biliary obstruction, but there are some obscure points. I have points to raise which may need some discussion and hope you will make some revisions to your manuscript. <Major comments> 1. Portal obstruction sometimes occurs in the patients with malignant hilar biliary stricture. The liver function of the segment of which portal vein is occluded relatively decreases. How do you deal with these liver segments in CT volumetry? 2. Can you make a discussion on the reason for the result "smaller drained liver volume was associated with drainage-associated cholangitis"? 3. Placement of single stent is technically easier than that of multiple stents regardless of the type of stents. Therefore, the information on the number of placed stent is important. How many cases of Bismuth IV strictures in which effective drainage was achieved via single stent placement do you have? 4. Chemotherapy for the patients with unresectable malignant biliary stricture, especially biliary carcinoma, can improve their prognosis. The management of jaundice and cholangitis is important for continuous chemotherapy for malignant hilar biliary strictures. If the tumor becomes larger, the



BAISHIDENG PUBLISHING GROUP INC

8226 Regency Drive, Pleasanton, CA 94588, USA

Telephone: +1-925-223-8242

Fax: +1-925-223-8243

E-mail: bpgoffice@wjgnet.com

<http://www.wjgnet.com>

drainage volume becomes smaller, which will hinder continuous chemotherapy. Therefore, the minimum drainage is not always effective for continuous chemotherapy. Do you have information about this? And, please discuss about this.

ESPS PEER-REVIEW REPORT

Name of journal: World Journal of Gastroenterology

ESPS manuscript NO: 14618

Title: Drainage strategy of unresectable malignant hilar biliary strictures by computed tomography volumetry

Reviewer's code: 00629072

Reviewer's country: United States

Science editor: Jing Yu

Date sent for review: 2014-10-18 12:00

Date reviewed: 2014-10-18 13:49

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

COMMENTS TO AUTHORS

I have reviewed the ms "Drainage strategy of unresectable malignant hilar biliary strictures by computed tomography volumetry" by Fukasara et al. The authors aimed to identify criteria for predicting successful drainage of unresectable malignant hilar biliary strictures (UMHBS). They state that no ideal strategy currently exists. With this statement I disagree: in general, radiologists aim draining both liver lobes whenever possible, aiming to the highest possible liver volume drained. Not surprisingly, the authors found that drained liver volume and decompensated liver cirrhosis were independent factors contributing to the effectiveness of drainage. Liver volume drainage $\geq 33\%$ in patients with preserved liver function and $\geq 50\%$ in patients with impaired liver function correlates with effective biliary drainage in UMHBS. Also not surprisingly, a smaller drained liver volume was associated with drainage-associated cholangitis. Unfortunately I have to conclude that I don't think the ms adds much new to the field, and thus I do not recommend it for publication in WJG.