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ESPS PEER-REVIEW REPORT

Name of journal: World Journal of Gastroenterology
ESPS manuscript NO: 16386
Title: IgG4-Related Autoimmune Pancreatitis, Sclerosing Cholangitis, and Sialadenitis: Case Report and Literature Review
Reviewer's code: 03104186
Reviewer's country: Chile
Science editor: Jing Yu
Date sent for review: 2015-01-16 21:35
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CLASSIFICATION	LANGUAGE EVALUATION	SCIENTIFIC MISCONDUCT	CONCLUSION
[ ] Grade A: Excellent	[ ] Grade A: Priority publishing	Google Search:	[ ] Accept
[ ] Grade B: Very good	[Y] Grade B: Minor language polishing	[ ] The same title	[ ] High priority for publication
[Y] Grade C: Good	[ ] Grade C: A great deal of language polishing	[ ] Duplicate publication	[ ] Rejection
[ ] Grade D: Fair	[ ] Grade D: Rejected	[ ] Plagiarism	[ ] Minor revision
[ ] Grade E: Poor		[Y] No	[Y] Major revision
		BPG Search:	
		[ ] The same title	
		[ ] Duplicate publication	
		[ ] Plagiarism	
		[Y] No	

COMMENTS TO AUTHORS

In an interesting case report, the authors present a patient suffering from autoimmune pancreatitis, treated successfully by steroids obtaining a complete recovery of pancreatic involvement and followed one year later by an IgG4 related sialadenitis, which recovered after a repeated brief course of steroids. The diagnosis of autoimmune pancreatitis (AIP) and IgG4 related sialadenitis is clearly established. The authors analyze the metachronous involvement of the distinct organs by the same IgG4 related disease (IgG4-RD). It is true, that extrapancreatic manifestations in IgG4 related systemic disease are synchronous in the majority, but metachronous involvement of other organs is not exceptional (Takuma K, Kamisawa T , Anjiki H et al: Metachronous Extrapancreatic Lesions in Autoimmune Pancreatitis. Inter Med 2010; 49: 529-533). However, the majority of these metachronous manifestations preceded the AIP and only one case of retroperitoneal fibrosis and another case of lymphadenopathy occurred later in the experiences described in this paper. A recent case report published in WJG presented a similar case, sialadenitis (Küttner tumor) one year after the pancreatic resection for AIP (Sun L, Zhou Q, Brigstock DR et al: Focal autoimmune pancreatitis and chronic

sclerosing sialadenitis mimicking pancreatic cancer and neck metastasis. World J Gastroenterol 2014; 20: 17674-79) These facts give interest to the case reported in this manuscript, when the recurrence of the IgG4 RD took place in the salivary glands without affecting simultaneously the pancreas. Questions and comments: 1. It is a point of discussion, whether the patient had really IgG4 related cholangitis. The thickening of the gallbladder wall and bile duct is not enough to distinguish between a true involvement of biliary system and the consequence of the pancreatic disease. In particular, intrahepatic bile ducts were dilated secondary to the obstruction and did not show signs of inflammation, irregularity. 2. ERCP was performed and participated somewhat in the diagnosis – which was clear already without ERCP. Biliary endoprothesis was placed to treat the slight jaundice, which generally quickly disappears after initiating steroid treatment, even if it is more pronounced. However, once the biliary tree contrasted, biliary stent placement seems to be justified in order to prevent cholangitis. But what was the indication of pancreatic stent placement? Which caliber stents were used? 3. What is the authors' opinion about maintenance therapy of their patient, with azathioprine and low dose of corticosteroids? Minor comments: 1. "pronounced yellowing" of the skin (page 1.)– bilirubin level was only moderately elevated. 2. In the text (page 2.), they describe "increased uneven metabolism" by PET scan in common bile duct and gallbladder wall, but it is not represented on the figure. 3. There are some minor problems with the English. 4. It is somewhat confusing that the meaning of "proximal" and "distal" is opposite in the bile duct and in pancreatic duct. While the anatomy, physiology and the direction of bile secretion determine the use of these words in the bile duct, in the case of the pancreatic duct these are determined by radiological and surgical anatomy. It results that "proximal" in the bile duct means far from the papilla and in the pancreatic duct near to the papilla. However, this nomenclature is usual in the literature. As concerns the manuscript, they eventually could replace these expressions with other descriptive words. It could be worthwhile that experts in biliopancreatic pathology have a discussion in order to resolve definitively this contradiction.

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[ ] Grade B: Very good	[Y] Grade B: Minor language polishing	[ ] The same title	[ ] High priority for publication
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[ ] Grade E: Poor		[Y] No	[ ] Major revision
		BPG Search:	
		[ ] The same title	
		[ ] Duplicate publication	
		[ ] Plagiarism	
		[Y] No	

COMMENTS TO AUTHORS

Comments; This is a case report of IgG4-RD, AIP and sialadenitis. The clinical course are impressive. However following points need to reconsider. 1. Based on the data that total bilirubin 52.70micro mol/L, direct bilirubin 3.6 micro mol/L, I am curious that the patient was suffered from indirect bilirubin dominant jaundice. 2. Page 1, 'yellowing of the patient's skin and sclera'. Is this correct? 3. The title, '…… and literature review' was too much. 'IgG4-related …… and Sialadenitis: A case report'. Might be enough.

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		[ ] Duplicate publication	
		[ ] Plagiarism	
		[Y] No	

COMMENTS TO AUTHORS

Comments: This is a case report of multiple manifestations of IgG4-RD, including the pancreas and parotides. It is an impressive and exemplary case of IgG4-RD and therefore worth publishing to obtain more attention for this underdiagnosed disease. However, there are some questions and comments: Major: 1. Stenosis of only the distal CBD is not a prove for sclerosing cholangitis, when the remaining intra- and extrahepatic ducts are only dilated and not stenosed. Swelling of the pancreas can result in a stenosis of the distal CBD and can be only a result of pancreatic involvement and not bile duct involvement. The dilation of the remaining ducts can be a result of the stenosis of the distal CBD by the pancreas head. AIP and sialadenitis are clearly present in this patient, this is not the case for cholangitis in my opinion. I am not sure whether the decribed PET/CT results can prove for cholangitis, without the irregular aspect of the bile ducts on ERCP. 2. Discussion: 'Since the patient was very responsive to corticosteroids, a tumor of pancreas and bile duct was ruled out.' I do think that a tumor is ruled out in this patient, but this statement is too bold in my opinion. A response to steroids in general can be helpful, but is not proving the absence of a tumor and must be interpreted

with caution. 3. Discussion: 'This case did not meet this as steroids were only administered for 14 months—an evidently inadequate duration.' Treatment protocols differ between continents (Asian vs Western countries). Japanese experience advises steroid maintenance therapy for a longer period (3 years), but Western studies describe different experience (Hart et al, Gut 2012; 0: 1-6) especially regarding the known side effects of long term steroid therapy. Nuance is needed regarding this statement. Minor: Some adjustments of English language are needed, for example: 1. Introduction: 'misdiagnosed systemic disease' instead of 'misdiagnosed systemic diseases' 2. Discussion: 'As this case presented with elevated serum IgG4, was responsive to corticosteroid treatment, and had pancreatic imaging consistent with the diagnosis of AIP, it met the AIP diagnostic criteria of Asia and International Consensus Diagnostic Criteria(ICDC)'.