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ESPS PEER REVIEW REPORT

Name of journal: World Journal of Gastroenterology
ESPS manuscript NO: 11993
Title: An unusual case of digestive hemorrhage: Celiac axis-Portal Vein arteiovenous fistula
Reviewer code: 02941671
Science editor: Yuan Qi
Date sent for review: 2014-06-17 19:36
Date reviewed: 2014-06-26 22:53

CLASSIFICATION	LANGUAGE EVALUATION	RECOMMENDATION	CONCLUSION
[ ] Grade A: Excellent	[ ] Grade A: Priority publishing	Google Search:	[ ] Accept
[Y] Grade B: Very good	[Y] Grade B: Minor language polishing	[ ] Existing	[ ] 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	[ ] Existing	[Y] Minor revision
		[ ] No records	[ ] Major revision

COMMENTS TO AUTHORS

The Liu et. al manuscript illustrates an unusual cause of GI hemorrhage. Congenital arterioportal fistulas (APF) are rarely encountered in clinical practice, and thus few clinicians have experience with their clinical presentations and management. This article encourages the clinician to consider a unique source of portal hypertension in a young patient with GI bleeding. It further provides a solid review of etiologies of pre-sinusoidal portal hypertension. The manuscript is formatted well and easy to read. In summary, this article is favorable for the publication once the authors addressed concerns noted below. Major Concerns: Abstract: The abstract gives a clear delineation of the topic background and case finding/intervention.It would be useful if some estimate of arterioportal fistula prevalence were included in the introduction. It is also unclear from reading the abstract/introduction what makes this case report unique. The authors should include a comprehensive summary of the literature to cover the topic of "cause and site of APF". Further, it is unclear from reading the introduction how endovascular aortic repair differs from the standard treatment modality.In other words, in the case report itself, the authors do not satisfactorily explain why they chose to pursue endovascular aortic repair versus the standard modality of IR intervention (placement of coils etc). Figure A: The CT scan images obviously require anonymization of patient identifying information. The graphics provide an excellent display of patient anatomy before and after endovascular aortic repair; however, the illustration of portal system during the arterial phase is

not convincing. Refer to article of PMID:23674881 for better demonstration of CT scan image as well as DSA to show the existence of APF. Figure B: Angiography of celiac artery failed to demonstrate the blood flow towards portal system. This indicates that the cystic lesion highlighted in the CT scan (can be called aneurysm) may not have a communication to portal system (or the blood communication to portal system is not significant). In addition, the aneurysm of the pancreas head should be fed by the superior pancreaticoduodenal artery; thus, the term of "fistula between celiac axis (celiac trunk) and portal system" needs to be revised unless authors demonstrate the direct communication between portal vein and celiac axis (celiac trunk). Figure C: It is difficult to interpret the authors' statement in the text "An aortogram revealed no endoleak and no blood flow entering into Portal Vein anymore, but proper hepatic artery and left gastric artery were not shown". If the intention of covered stent placement in the celiac system is to shut down communication with the aneurysm of pancreas head, the blood flow to proper hepatic artery should not be obligated. The authors should explain the intention of this sentence in detail. Discussion: The discussion is well organized. The authors provide a reasonable theory as to what may have caused the APF to form. However, the major concern of this case report is that authors did not adequately demonstrate that this patient suffers from portal hypertension. Blood test of low platelets, spleen size description, portal system pressure measurement during IR procedure, and/or EGD based evidence (varices or gastropathy, etc) should be shown. Otherwise this case cannot be distinguished from hemosuccus pancreaticus, which can also cause intractable GI hemorrhage. Minor Concerns: 1. The blood pressure on arrival of 122/613mmHg should be corrected. 2. It will be recommended to have blood test result on admission as it justifies the absence of liver disease or cirrhosis as a cause of portal hypertension. 3. It has been noted quite many typos and thus careful polishing is needed.