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ESPS PEER-REVIEW REPORT

Name of journal: World Journal of Gastroenterology
ESPS manuscript NO: 26049
Title: Portal biliopathy
Reviewer's code: 02591964
Reviewer's country: India
Science editor: Jing Yu
Date sent for review: 2016-03-29 13:57
Date reviewed: 2016-04-17 16:31

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

1. This is an important review article on portal biliopathy (PBP) as this aspect of EHPVO is not often addressed adequately. 2. Anatomy and history section need to be shortened. Detailed liver lobar anatomy is not required rather authors should confine the description to clinically relevant biliary and portal venous anatomy. 3. Cholangiographic findings of portal biliopathy have been repeatedly mentioned at many places (historical background, diagnosis sections). 4. It is important of describe the natural history of PBP with and without endoscopic management of esophagogastric varices, and in patients with EHPVO and patients with cirrhosis. With the increasing use of endoscopic management of esophagogastric varices, symptomatic PBP may become more common due to the diversion of portal pressure towards hepatoduodenal ligament. Authors should cover this aspect in this review. 5. Few important articles (e.g. Vibert et al, Ann Surg 2007) have not been included in this review. 6. Authors should suggest the appropriate management line in patients with non-shuntable splenic vein or in cases with extensive splenoportal thrombosis: mesocaval shunt or PTBD or ant thing else. This group, though small, might be the most difficult to manage. 7. Authors should clarify the utility and difficulty with SEMS in these patients considering the benign nature of

the disease and difficulties with subsequent retrieval of these stents, or intraoperative difficulties lest these patients require surgical management of persistent biliary problems. 8. Long term outcome with TIPS in these patients should be clarified considering the high occlusion rate of TIPS after 1 year. 9. In the section "Historical Background" last 2 lines: "However, I believe....." should change to "authors believe.....". 10. In the clinical disease section: "Mean serum bilirubin level was 2.7 mg/dl in one study while only 15% of patients had a bilirubin value of more than 5 mg/dl in another study" . Please provide references for these studies. 11. Management section: Management under following category is suggested for better understanding: A: Asymptomatic patients; B: Medical / Endoscopic Management, C: Surgical Management. 12. It would be helpful for the readers to understand this subject if authors could provide tabulated summary of important series on this important topic (Agarwal et al 2011, HPB; Vibert et al Ann Surg 2007 etc). 13. A summary at the end should be added.

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ESPS PEER-REVIEW REPORT

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CLASSIFICATION	LANGUAGE EVALUATION	SCIENTIFIC MISCONDUCT	CONCLUSION
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		[Y] No	

COMMENTS TO AUTHORS

1. There is a lot of repetition on cholangiographic findings (in various sections MRCP/ERCP/historical information taking up too much space. The management section can be expanded. Some discussion on reported outcomes and long-term follow up data or lack of it would also help make the paper better 2. Core tip: Now, portal biliopathy is an important clinical entity faced by hepatologists in India. May be reframed so as to say it is being increasingly encountered. Is this section supoosed to be the summary of the review. If not a brief summary would also help 3. Definition: Portal cavernoma causes these biliary abnormalities through several pathogenic mechanisms. The pathogenesis is discussed later in detail and looks repetitive 4. Biliary anatomy describes a lot of liver anatomy especially the intrahepatic biliary tree which is not very relevant to the subject being discussed. 5. Diagnosis: considering invasive nature of ERCP, it should be mentioned later in the evaluation (atleast after usg and MRCP) to put things into perspective maybe even after EUS. Also there is a lot of repetition with quite a lot of these being mentioned in the historical section as well as in the MRCP section. 6. Management a. This section should be expanded b. It may be made into small subsections with subheads being endotherapy, surgery etc. c. Biliary

surgery namely surgical removal of CBD calculi o bilio-enteric anastomosis without prior portal decompression carries high mortality and hence is contraindicated. Statement is controversial. Better reframed as should be avoided. This statement should also come after the entire section on endotherapy d. The fact that cholecystectomy (and my be even laparoscopic as recently reported by John S et al) can be safely done even in patients with pericholecystic collaterals must be mentioned considering the authors have cited their initial bad experience with this procedure in historical perspectives 7. Algorithm: It will be good to add a box saying that about feasibility of shunt/tips: yes-shunt/tips, no-metal stenting.

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COMMENTS TO AUTHORS

Nice review with good illustrations