

Dear Editors and Reviewers,

Thank you for providing us with the opportunity to revise our manuscript entitled "Effect of intradermal needle therapy at combined acupoints on patients' gastrointestinal function following surgery for gastrointestinal tumors" (Manuscript NO.: 78765). We would like to express our appreciation for your patience, as well as your careful and thorough examination in the process of reviewing our manuscript. The feedback was thoughtful and informative, and we believe this manuscript has significantly benefited from your input. We have reviewed the comments and suggestions carefully and made the corresponding revisions in the manuscript. Revisions in the manuscript are shown in red font. We hope that the revisions and our accompanying responses will enable further consideration of our manuscript for publication in the World Journal of Clinical Cases.

Responses to the comments and suggestions from the reviewers point by point

Reviewer #1:

Specific Comments to Authors:

#1 Intradermal needle therapy (INT) was continued for 1 week, but is there anything on the control group? If there is at least no needle attached, is the patient aware of this? If patients can recognize these things, then the placebo effect cannot be ruled out and at least seems to be included in the study limitation. The authors should elaborate on the procedure, especially in the control group.

Response: We are genuinely grateful for your constructive suggestions. We apologize for the ambiguity in the original manuscript. The patients in the control group did not receive INT. However, adhesive tapes were attached at their corresponding acupoints with the same appearance as the adhesive tapes with needles applied to the acupoints of the patients in the intervention group, to control for placebo effects.

We have added more information regarding the procedures use in the MATERIALS AND METHODS - *Intervention* section and in Table 1.

#2 The authors should state whether there is a difference in treatment effect on GI function, GI symptoms in the INT and control groups between gastric cancer and other colon cancers

Response: Thank you very much for your suggestion. We have presented the results of the subgroup analysis in the RESULTS section and in Tables 3 and 5.

#3 Some of the tables are shown in the second decimal place. The authors should show them in meaningful decimals and whole numbers, as they are not clinically meaningful.

Response: Thank you very much for your advice. We have revised the decimal places of the data in the tables accordingly. The guidelines of World Journal of Clinical Cases do not give any specific instructions regarding the number of significant figures when reporting p-values. The New England Journal of Medicine (NEJM) states: "In general, P values larger than 0.01 should be reported to two decimal places, those between 0.01 and 0.001 to three decimal places; P values smaller than 0.001 should be reported as $P < 0.001$." Therefore, we have made changes to the p-values accordingly.

Reviewer #2:

Specific Comments to Authors: This study is a clinical study, which mainly discussed the intradermal needle therapy at combined acupoints on patients' gastrointestinal function following surgery for gastrointestinal tumors. this study found INT at the Yuan-source, Luo-connecting, and He-sea points in patients could decrease their time to first postoperative flatus passage, oral feeding, and defecation and alleviate their symptoms, including abdominal distension, nausea, vomiting, and fatigue 48 h and 72 h after surgery. The main problem is that most of the observed indicators are the patients' self-symptoms, the defecation time is also affected subjectively, the objective index is less, and the sample size is small.

Response: Thank you very much for your comments. As you have stated, we used self-reported indicators as outcomes. This is one of the limitations of this study.

Postoperative inhibition of GI motility results in impaired intestinal transit, leading to signs and symptoms such as bloating, nausea, vomiting, delayed passage of flatus

and stool, and the inability to tolerate solid food. As improvement of these parameters is believed to be an accurate representation of recovery of GI transit, many clinical trials have used the time to first flatus passage and defecation as primary and/or secondary outcome measures (1–4). Moreover, objective methods to assess GI symptoms remain scarce.

In addition, during the recording and assessment of outcomes, strict quality control was performed to ensure the authenticity and accuracy of these indicators.

Nevertheless, we appreciate your constructive comments. We have added a discussion of these limitations to the DISCUSSION - *Strengths and limitations* section of the manuscript. In future studies, we will continue to explore the effect of this technique by using larger sample sizes and collecting more objective outcome measures.

See the sentences in the manuscript “First, the small sample size must be acknowledged. Although we conducted a subgroup analysis based on the type of cancer, the reliability of the subgroup analysis results might be limited by the relatively insufficient sizes of each of the subgroups. Therefore, further studies focusing on a specific type of cancer should be conducted to validate the findings. Second, self-reported indicators were used as the outcomes in this study, and this could have resulted in self-reported bias. In future studies, the effect of INT at the Yuan-source, Luo-connecting, and He-sea points will be further explored using larger sample sizes and collecting more objective outcome measures.”

References

[1] Zhang B, Zhu K, Hu P, Xu F, Zhu L, Chen JDZ. Needleless Transcutaneous Neuromodulation Accelerates Postoperative Recovery Mediated via Autonomic and Immuno-Cytokine Mechanisms in Patients With Cholecystolithiasis. *Neuromodulation*. 2019 Jul;22(5):546-554. doi: [10.1111/ner.12856](https://doi.org/10.1111/ner.12856). Epub 2018 Oct 1. PMID: [30277014](https://pubmed.ncbi.nlm.nih.gov/30277014/).

[2] van Bree SH, Bemelman WA, Hollmann MW, Zwinderman AH, Matteoli G, El Temna S, The FO, Vlug MS, Bennink RJ, Boeckxstaens GE. Identification of clinical outcome measures for recovery of gastrointestinal motility in postoperative ileus. *Ann Surg*. 2014 Apr;259(4):708-14. doi: [10.1097/SLA.0b013e318293ee55](https://doi.org/10.1097/SLA.0b013e318293ee55). PMID:

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[3] Wang L, Zhang X, Xu H, Zhang Y, Shi L. Influencing Factors of Gastrointestinal Function Recovery after Gastrointestinal Malignant Tumor. J Healthc Eng. 2021 Oct 13;2021:6457688. doi: [10.1155/2021/6457688](#). PMID: [34691379](#); PMCID: [PMC8528622](#).

[4] Shi J, Li S, Wang Y, Zheng L. Retrospective study on recovery of 521 gastrointestinal tumor patients after laparoscopic surgery. Oncol Lett. 2018 Sep;16(3):3531-3536. doi: [10.3892/ol.2018.9064](#). Epub 2018 Jul 4. PMID: [30127958](#); PMCID: [PMC6096134](#).

Reviewer #3

Specific Comments to Authors

The authors describe the effect of novel acupuncture technique on postoperative GI function recovery. The article is an interesting concept but there are some concerns

Response

We are genuinely grateful for your kind comments and very helpful suggestions.

1. The language needs to be edited

Response: Thank you. The language has been checked and edited by an English language editing service.

2. ERAS protocol was followed in the patients in both groups. There are many components in preoperative period, intraoperative and postoperative period. The compliance of ERAS is always a concern and may affect the GI recovery. What was the compliance of ERAS protocols among the participants of both the groups with respect to various components.

Response: Thank you very much for your question. During the implementation of the study, the following strategies were adopted to ensure compliance with the ERAS components: all the patients were treated and cared for by the same medical

team; also, two researchers regularly communicated and coordinated with clinicians, anesthesiologists, dietitians, and nurses to supervise the implementation of ERAS components and Traditional Chinese Medicine.

In this study, four of the ERAS components (preoperative optimization, postoperative tube management, postoperative early oral intake, and early mobilization) had compliance rates ranging from 71.9% to 84.4%. The other ERAS components had compliance rates of 85% or greater. Specifically, the compliance rates of preoperative optimization in the intervention and control groups were 84.4% and 81.2%, respectively. Meanwhile, the compliance rates of postoperative tube management in the intervention and control groups were 84.4% and 75.0%, respectively. The compliance rates of postoperative early oral intake in the intervention and control groups were 78.1% and 71.9%, respectively. The compliance rates of early mobilization in the intervention and control groups were 71.9% and 75.0%, respectively. No differences were found between the two groups in terms of the compliance rates of preoperative optimization, tube management, postoperative early oral intake, or early mobilization.

We have added these descriptions in *Compliance with ERAS components* in the RESULTS section.

3. who recorded " time to first flatus and stool passages and time to first oral feeding" and how frequently was this recorded to ensure consistency

Response: Thank you for this important question. During preoperative counselling and patient education, the patients or their families were taught how to identify and record the time to first flatus and stool passages and the time to first oral feeding. They were prompted to inform nurses immediately after their first postoperative flatus passages. On the first day after the operation, the nurse interviewed the patient or their family about the time of their first flatus and stool passages every 4 h. These descriptions have been added in the MATERIALS AND METHODS - *Outcomes* section.

4. Was the outcome assessor blinded to the study group allocation

Response: Thank you for your question. Yes, the outcome assessors were blinded to the study group allocation. Please kindly see the description “data collectors were blinded to the group assignment” in the MATERIALS AND METHODS - *Randomization and blinding* section.

5. What was the preoperative fasting status of patients and did they receive any maltodextrins within 2-3 hours before anesthesia in both groups. Also what was the time when feeding was initiated in both the groups postoperatively?

Response: Thank you very much for your question.

The patients’ preoperative fasting status was as follows: fasting from solid foods for 6 h before surgery; 2–3 h before surgery, patients without diabetes received 200–350 mL of electrolyte drinks under the guidance of dietitians (ingredients: glucose 100 mmol/L, sodium 50 mmol, potassium 20 mmol/L, chloride 50 mmol/L, magnesium 1 mmol/L, phosphorus 2 mmol/L); water was prohibited during the 2 h before surgery. We have added these descriptions to **Table 1** (“Preoperative fasting and carbohydrate loading”).

Patients were encouraged to drink when they were awake after the operation. If there was no discomfort, a liquid diet was allowed after the first postoperative flatus passage, and the semi flow and general diet were gradually recovered.

6. Please check the acceptable number of tables in guidelines and modify accordingly

Response: Thank you. We have reduced the number of tables to the limit given by the guidelines, according to your suggestion.

7. Also a subgroup analysis of gastric vs colon cancer should be done

Response: Thank you very much for your suggestion. We have added the results of the subgroup analysis in the RESULTS section and in Tables 3 and 5.

EDITORIAL OFFICE’S COMMENTS

Authors must revise the manuscript according to the Editorial Office's comments and suggestions, which are listed below:

(1) Science editor:

The manuscript has been peer-reviewed, and it's ready for the first decision.

Language Quality: Grade B (Minor language polishing)

Scientific Quality: Grade C (Good)

(2) Company editor-in-chief:

I recommend the manuscript to be published in the World Journal of Clinical Cases. Before final acceptance, when revising the manuscript, the author must supplement and improve the highlights of the latest cutting-edge research results, thereby further improving the content of the manuscript. To this end, authors are advised to apply a new tool, the Reference Citation Analysis (RCA). RCA is an artificial intelligence technology-based open multidisciplinary citation analysis database. In it, upon obtaining search results from the keywords entered by the author, "Impact Index Per Article" under "Ranked by" should be selected to find the latest highlight articles, which can then be used to further improve an article under preparation/peer-review/revision. Please visit our RCA database for more information at: <https://www.referencecitationanalysis.com/>.

Response: Thank you for this insightful suggestion. As suggested, we have applied the Reference Citation Analysis (RCA) to identify the latest highlight articles. We summarized these articles and added them in the **Introduction** section.

See the sentences in the manuscript "Due to its notable therapeutic advantages, INT has recently been applied in the treatment of a range of conditions. A recent protocol developed a randomized controlled trial to examine whether INT at the Shenmen (HT36) and Sanyinjiao (SP6) acupoints would improve postoperative sleep quality in patients undergoing laparoscopic hysterectomy [15]. One study explored the effects of INT on hemiplegia recovery after stroke [16], while another study summarized the effectiveness of INT for treating gastric diseases by describing clinical cases [17]. Previous research applied INT in combination with pinaverium bromide in irritable bowel syndrome-diarrhea patients and found that this technique effectively regulated gastrointestinal hormone production and significantly improved gastrointestinal symptoms [18]."