

## ANSWERING REVIEWERS

July 22, 2013

Dear Editor,

Please find enclosed the edited manuscript in Word format (file name: ESPS-4133.doc).

**Title:** Endoscopic common bile duct stone extraction and Laparoscopic cholecystectomy at the same session as a routine procedure: Feasibility and safety

**Author:** Jin-Feng Zang, Chi Zhang, Jun-Ye Gao

**Name of Journal:** *World Journal of Gastroenterology (WJG)*

**ESPS Manuscript No:** 4133

**The manuscript has been improved according to the suggestions of reviewers:**

**1 Format has been updated following the guidelines of WJG.**

**2 Revision has been made according to the suggestions of the reviewer**

(1) **Comments from the reviewer:** It is an interesting study but one of the objections is that the same surgeon who performed laparoscopy and ERCP. Although this is a situation possible not all surgeons performed laparoscopy and ERCP. Habitually ERCP is performed by a gastroenterologist experienced in endoscopy. This situation is not enough to reject the publication of the paper because a few words about it can clarify the situation and do not change the essentials of the investigation. The authors are missing discussions on the advantages of ERCP performed simultaneously or deferred with the exploration of the bile ducts, in the same surgery, through the cystic duct or common bile duct examination (choledocotomy) via laparoscopy.

**Answer:** We agree with the reviewer that ERCP is usually performed by a gastroenterologist experienced in endoscopy. The aim of this study was not to encourage surgeons to master ERCP technique. Surgeons and gastroenterologists tend to exaggerate the effect of their own technique. Because surgeons seldom manipulated laparoscopy and ERCP simultaneously, the value of our study was its objectivity and impartiality from a real neutral's point of view when comparison was made between ERCP and LCBDE. Despite continuing improvement in the technology and expertise in laparoscopic techniques, LCBDE is certainly not a panacea to manage all CBD stones. For example, it is restricted when CBD is not dilated. Patients' sufferings from the placement of T-tube pose another disadvantage. As debates on optimal choice for CBD stones have not been stopping, the conclusion that

LCBDE might replace ERCP cannot be drawn at least for now.

- (2) **Comments from the reviewer:** In this study, the authors present data on endoscopic common bile duct stone (ES) extraction and Laparoscopic cholecystectomy (LC) at the same session as a routine procedure. The data of the study show that there is no statistically significant difference between patients having ES and LC the same day *vs* ES and LC a few days later. In the abstract, the authors state in the Method that this is a retrospective study, but this is not reported anywhere in the body of the manuscript. Contrary to a retrospective type of study, in the Material and Method sections, the authors report that “the study was registered in our ethics committee”. Also, in Tables 2 and 3, the authors report time (min) for each endoscopic procedure and time to flatus after LC. In my opinion, these records are not usual for every day practice in a retrospective study. The above, are confusing to me, as it is crucial to know whether this is a prospective or retrospective study.

**Answer:** This study focused on the feasibility and safety when ERCP and LC were performed at the same session as a routine procedure. There were no statistically significant differences in most of the indexes. The total hospital stay of group 1 was shorter than that of group 2 (see Outcomes of laparoscopic cholecystectomy in Results). Actually the total cost of hospitalization was reduced in group 1 (not presented in this study). Furthermore, patients in group 1 obviously suffered from fewer mental stimuli because of using the combination of the two procedures, though there was no objective index used to evaluate this psychological difference.

This was a retrospective study as stated in line 3 in Materials and Methods. As a tertiary general hospital, regulations on clinical studies are strict. All clinical studies must be registered and approved by our ethics committee and conducted under its supervision. Combination of ERCP and LC at the same session as a new procedure was registered in and approved by our ethics committee. We must collect relative clinical data on this procedure and its counterparts, and report to the ethics committee in time. On the other hand, data on many conventional procedures, such as LC and LA, must be gathered under Clinical Quality Control at our hospital.

- (3) **Comments from reviewer:** In this study, the authors evaluated the safety and feasibility of common bile duct stones extraction via ERCP and laparoscopic cholecystectomy (LC) at the same session as a routine procedure. There was no statistically difference in the outcome of patients having ERCP and LC at the same session compared to patients having ERCP and LC three days later. The article is interesting, but some critical points have to be discussed: 1. The main problem is the retrospective nature of the study. It is not clear how the patients were enrolled in the study: there was a choice of the patient or the surgeon?

2. The assumption that the same surgeon perform both ERCP and LC may be a problem, since laparoscopic exploration of the common bile duct is increasingly and successfully performed by experienced laparoscopic surgeons (such as the authors of this study), avoiding unnecessary ERCP. This point should be more extensively discussed.

**Answer:** 1. "The study was approved by our ethics committee, and written consent was obtained from each patient. After being informed about the related therapeutic maneuver, the patients chose the sequence of endoscopic procedure and LC. According to this sequence, the patients were further classified into two groups." It has been clearly stated that surgeons informed patients of therapeutic maneuver and patients chose their own therapy (see paragraph 1 in Materials and Methods); 2. As we described above, the aim of this article was not to encourage surgeons to master ERCP technique. ERCP and LC performed at same session can also be realized by cooperation between surgeons and gastroenterologists. Diagnostic value of ERCP in biliary diseases, especially benign disease, has depreciated dramatically. At present, MRCP gradually becomes a competitive alternative, which is thought to be a noninvasive diagnostic technique in biliary diseases [Ref.16-18]. How to avoid unnecessary ERCP was not the focus of this study. There has been a consensus on rational utilization of all available examinations in diagnosing CBD stones, including biochemical test, ultrasonography, MRCP and ERCP. LCBDE was discussed in paragraph 4 of Discussion. Because LCBDE was not included in this study, we could not give more information about it. We will compare ERCP and LCBDE in our future studies.

### 3 References and typesetting were corrected

Thank you again for publishing our manuscript in the *World Journal of Gastroenterology*.

Sincerely yours,



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