# Format for ANSWERING REVIEWERS

January 19, 2015

Dear Editor,

Please find enclosed the edited manuscript in Word format (file name:00227582,00045831,00068723, 02823396,00160226-review.doc).

**Title:** Therapeutic ERCP in a patient with situs inversus viscerum

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**Name of Journal:** *World Journal of Gastroenterology*

**ESPS Manuscript NO:** 15271

The manuscript has been improved according to the suggestions of reviewers:
1 Format has been updated

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

For 00227582-reviewer

(1)This is an interesting study but needs grammatical improvement.which is unusual position in ERCP at the beginning?Why is it an unusual position in ERCP at the beginning? Expand and expound on this.

Answer:We have improved the sentence structure and revised the grammatical error.

ERCP in supine position is difficult for three reasons:first,the head could not be fixed easily in a natural position;second,cannulation was difficult when the papilla sank into the intestinal wall because of the effect of gravity and the diverticulum,which increased the difficulty of intubation and likelihood of papillary edema and damage to the pancreatic duct.In addition,the stomach could not be fixed for stability of the endoscope in the supine position.For these reasons,ERCP usually begin when the patient is positioned to a prone position with the face turned to the right side or approximate a left-lateral decubitus position.

(2)Is Isto Nordback a single surname? Use surname and initial or surname only.

Answer:Nordback is a surname,we have modified this point.

For 00045831-reviewer

(1)The manuscript describes ERCP in situs inversus viscerum.I agree with the authors its a rare and difficult ERCP.However,the technique of ERCP in situs inversus is already well described in literature.

Answer:our article has a review for those literature and we conclude that therapeutic ERCP is a safe procedure for patients with SIV,and ERCP can be performed more smoothly with conversion of the patient's position or the use of special techniques.To our knowledge,this case is the first reported in China.

For 00068723-reviewer

(1)As the authors state,situs inversus viscerum is a very rare condition.Technical issue on ERCP was the major theme of this report.Supine-prone position was rare in the literature.The reason of "supine-prone" position should be described.Most of the literature use left-side down (normal) or right-side down.Pros and cons of "supine-prone" position should be described,comparing left-side down or right-side down.

Answer:In our case,because the position of the upper gastrointestinal tract and pancreaticobiliary duct is a mirror image of the normal anatomy,the endoscopist began intubation with the patient in a

supine position.Following intubation,however,this technique became difficult for three reasons:first,the head could not be fixed easily in a natural position;second,cannulation was difficult when the papilla sank into the intestinal wall because of the effect of gravity and the diverticulum,which increased the difficulty of intubation and likelihood of papillary edema and damage to the pancreatic duct.In addition,the stomach could not be fixed for stability of the endoscope in the supine position.For these reasons, the patient was repositioned to a prone position with the face turned to the right side.

(2)Where did the operator of ERCP stand in this case report?

Answer:The endoscopist standed at the left side of the patient who faced to the left side.

(3)Were there any evidence, such as chest X-ray or CT, that clearly suggested SIV?

Answer:Chest X-ray revealed the tip of the heart was at the right side**(Figure 1)**.

(4)What is liver-protecting treatment? Please describe clearly and in detail, such as names of drugs.

Answer:We use Glutathione(1.2g per day) because alanine transaminase (ALT) was 58U/L,aspartate transaminase (AST) was 51U/L.

(5)Which side was the entrance of the esophagus found,right or left in SIV in this patient?Normal position or opposite? This information would be helpful for inserting endoscopy.

Answer:The entrance of the esophagus was in the normal position,in the rear of the trachea.

(6)How about ALP? When G-GTP was above 1000,ALP should be normally elevated.Table of laboratory data are necessary to evaluate the patient.

Answer:ALP was in the normal range,and laboratory data was given.

(7)Name and location of the all the devices should be presented.

Answer:ERCP was performed with a side-viewing endoscope(Olympus JF-260).Cannulation was performed with a standard sphincterotome[Boston Scientific，Rx44(Autotome）4.4F(1.5mm)20mm] and jag wire measuring 450 cm×0.035 inch(0.89 mm).Cholangiography showed that the biliary ducts had filling defects (Philip fluoroscopy equipment).After a standard sphincterotomy and balloon dilation(Olympus FG-301Q),the stone was removed with a Dormia basket(Olympus FG-301Q Figure 5).Monitor was placed on the opposite side of the patient,at a level above the head of the table directly in front of the endoscopist.

For 02823396-reviewer

(1)The authors reported to us how to perform ERCP in a patient with situs inversus or SIV.They have not any complication and the technique can be performed as usual.

For 00160226-reviewer

(1)Can the authors comment on special considerations on cannulation and sphincterotomy in this patient with situs inversus?

Answer:In our case,because the position of the upper gastrointestinal tract and pancreaticobiliary duct is a mirror image of the normal anatomy,the endoscopist began intubation with the patient in a supine position.Following intubation,however,this technique became difficult for three reasons:first,the head could not be fixed easily in a natural position;second,cannulation was difficult when the papilla sank into the intestinal wall because of the effect of gravity and the diverticulum,which increased the difficulty of intubation and likelihood of papillary edema and damage to the pancreatic duct.In addition,the stomach could not be fixed for stability of the endoscope in the supine position.For these reasons,the patient was repositioned to a prone position with the face turned to the right side.However,routine maneuvers became difficult in the second part of the duodenum;therefore,the endoscope was rotated clockwise to 180° with some torsion and shortening.A sphincterotomy was performed,although due to the diverticulum and altered CBD anatomy,the biliary orifice was located in the right upper quadrant,corresponding to the 1 o'clock position.

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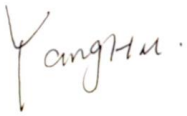
3 References and typesetting were corrected

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

Sincerely yours,



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