Format for ANSWERING REVIEWERS

June 08, 2015

Dear Editor,

Please find enclosed the edited manuscript in Word format (file name: revised manuscript (17841).docx).

Title: Innovative technique of needlescopic grasper-assisted single-incision laparoscopic common bile duct exploration: A comparative study

Author: Say-June Kim, Kee-Hwan Kim, Chang-Hyeok An, Jeong-Soo Kim

Name of Journal: *World Journal of Gastroenterology*

ESPS Manuscript NO: 17841

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 manuscripts submitted by non-native speakers of English, please provided language

certificate by professional English language editing companies mentioned in 'The Revision Policies of BPG for Article'.

RESPONSE) We provided the language certificate by one of the professional English language editing companies.

Please provide the postal code

RESPONSE) We provided it. Thank you.

Authors are required to make these statements in the manuscript's title page (please see sample wording in attachment). A copy of any approval document(s)/letter(s) or waiver of confirmation must also be provided in PDF format. BPG will include all the confirmations along with the manuscript as a permanent part of the online publication.

Please provide these files needed for retrospective study, each in a separate PDF file, signed by the Correspondence author or a copy of Institution approval document(s)/letter(s) or waiver of confirmation. For sample wording and detailed information, please see the Revision policy in the attachment or Instruction to authors on our website. Thank you!

RESPONSE) We provided the required statements and attached the certifying files. Thank you.

METHODS should be no less than 140 words.

RESPONSE) The abstract method section has been changed to include no less than 140

words. Thank you.

Core Tip

RESPONSE: We included the required core tip. Thank you.

Audio Core Tip

In order to attract readers to read your full-text article, we request that the first author make an audio file describing your final core tip. This audio file will be published online, along with your article. Please submit audio files according to the following specifications:

Acceptable file formats: .mp3, .wav, or .aiff

Maximum file size: 10 MB

To achieve the best quality, when saving audio files as an mp3, use a setting of 256 kbps or higher for stereo or 128 kbps or higher for mono. Sampling rate should be either 44.1 kHz or 48 kHz. Bit rate should be either 16 or 24 bit. To avoid audible clipping noise, please make sure that audio levels do not exceed 0 dBFS.

RESPONSE) We attached the audio core tip according to the instruction. Thank you.

Don’t need blank space between reference number and the before words.

Please check throughout. Thank you!

RESPONSE) Throughout the manuscript, we have checked and confirmed that there is no

blank space between reference number and the before words

At least 30 references should be included, covering important publications cited in PubMed within the past 4 years. For seminal references, however, the publication date is not strictly limited.

RESPONSE) We included total 32 references. Thank you.

COMMENTS

Please provide the "Highlighted contents" here, which is a necessary content. See the requirements as follows:

RESPONSE) We proved the highlighted contents in the designated space. Thank you.

3 References and typesetting were corrected

Authors greatly appreciate your time and consideration and look forward to hearing from you.

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

Sincerely yours,

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Format for ANSWERING REVIEWERS

August 24, 2015

Dear Editor,

Please find enclosed the edited manuscript in Word format (file name: 17841-Review_V0.3 (DECODE)).

The authors would like to thank the editors and reviewers for their time and their valuable comments.
We believe that the problem has occurred in the processing process of paper.
We thought we had submitted the paper which had been modified according to the reviewers' points, but found that it was not reflected.
Therefore, we send the fixed paper based on the reviewers' points.

Title: Innovative technique of needlescopic grasper-assisted single-incision laparoscopic common bile duct exploration: A comparative study

Author: Say-June Kim, Kee-Hwan Kim, Chang-Hyeok An, Jeong-Soo Kim

Name of Journal: *World Journal of Gastroenterology*

ESPS Manuscript NO: 17841

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

1. (abstract, L16) There is no unit of the amount of the analgesic.

RESPONSE) Thanks for pointing out this omission. It is mg/kg. The manuscript text has been changed to correct this.

2. (P6, L2) You must mention how to detect stone using a rigid nephroscope.

RESPONSE) In performing nSIL-CBDE, we selectively used a rigid nephroscope. Rigid

nephroscopes are commonly used by urologists for percutaneous nephrolithotomy. It accommodates wide graspers, thereby making it possible to extract large stones under the direct vision. Therefore, it was commonly indicated at the time of failing extracting stones using stonebasket forcep or Fogarty catheter.

We addressed the usage of the rigid nephroscope in the method section as follows. Thank you.

“In extracting residual stones, we selectively used a rigid nephroscope (17-Fr, 6°; Karl-Storz). It accommodates wide graspers, thereby making it possible to extract large stones under the direct vision. Therefore, it was commonly indicated at the time of failing to extract stones using stonebasket forcep or Fogarty catheter.”

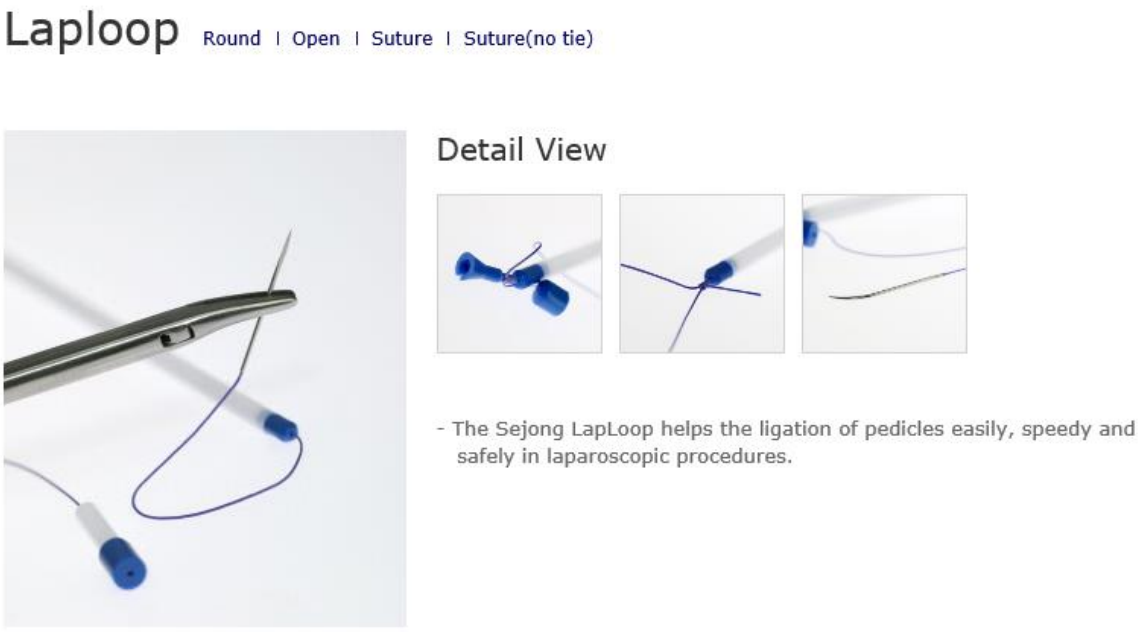
3.(P6, L5)This is the first important point in this article. Can you get visualization of the lower part of the CBD using choledochoscope through the umbilical port in all cases? How can you have it?

RESPONSE) We apologize that our inaccurate expressions in the manuscript has caused the misunderstanding. Rigid nephroscope is easy to handle, but has limitations in providing the full visualization of CBD. Therefore, we intermittently used the rigid nephroscope for the convenient reasons, and however in all series of nSIL-CBDE, flexible choledochoscope finally confirmed the presence of remained stones in the CBD. To properly visualize the lower portion of CBD, the choledochoscope was gently pushed toward the distal CBD using a needlescopic graper (Minilap or Endorelief). The manuscript has been changed to avoid the misunderstanding of readers as follows. Thank you.

"Afterwards, for the detection of residual CBD stone(s), CBDE was performed using a flexible choledochoscope (11-Fr, 30°; Karl-Storz). During choledochoscope manipulation (Fig. 3 & 4), the needlescopic grasper effectively assisted the insertion of the choledochoscope into the CBD and changes in direction. It gently pushed the choledochoscope toward upper and lower part of the CBD to properly visualize both directions, enabling thorough visualization of both the upper (up to the right and left hepatic ducts) and lower (down to the papilla) portion of the CBD. Any residual stones were removed using a Stonebasket forcep (Olympus) or Fogarty catheter. In extracting residual stones, we selectively used a rigid nephroscope (17-Fr, 6°; Karl-Storz). It accommodates wide graspers, thereby making it possible to extract large stones under the direct vision. Therefore, it was commonly indicated at the time of failing to extract stones using stonebasket forcep or Fogarty catheter."

4.(P6, L12) What is the Lap-suture?? You had better explain how to repair CBD using Lap-suture?.

RESPONSE) Lap-suture is a pre-knotted suturing material which enables convenient suturing just by suturing, passing the needle through the pre-knotted hole, and then tightening it by pushing using a bar. The following picture shows Lap-suture (it is also called lap loop). We added detailed description (as above) of Lap-suture in the manuscript. Thank you.



5.(P6, L19) From where and how do you insert a drain in nSIL-CBDE?

RESPONSE) In nSIL-CBDE, we have basically have no drain policy; however, we inserted the drain, especially in earlier series or thereafter occasionally only when there was fragile CBD tissue due to severe inflammation. The drain was placed in the subhepatic space through the direct punctured site in which the needlescopic grasper was entered. The drain was usually removed within 48 h after surgery, if there was no evidence of bile leakage.

6.(P6) You should briefly mention the method of conventional laparoscopic CBDE.

RESPONSE) Thank you for your helpful comment. We added the following descriptions in the operative method section.

“In performing CL-CBDE, standard 4-port approach was utilized: one 10-mm infra-umbilical port

for laparoscope, one 5-mm subxipholdal, one 5-mm right flank, and one 5-mm ports along the midclavicular line below the right subcostal region. After meticulous dissecting the Calot's triangle, the critical view of safety was obtained. The cystic artery was clipped and divided, and then cystic duct was clipped. After making 5- to 10-mm vertical choledochotomy, CBD stone retrieval was attempted using a Stonebasket forcep (Olympus), Fogarty catheter, or triflange forceps (through a rigid nephroscope). To confirm the clearance of CBD, intraoperative cholangiography or flexible choledochoscopic exploration was performed. After CBD repairing, the gallbladder was completely removed from the liver, and trocar sites were repaired."

7. (P8, L15) You should letter the unit of the analgesic.

RESPONSE) Thanks for pointing out this omission. It is mg/kg. We have added the unit.

8.(P8.L22)This is the second important point. I think that nSIL-CBD reduced intravenous analgesic administration and the length of hospital, because the drain were less frequently placed in its patients. You should explain about it.

RESPONSE) Thank you for your insightful and relevant comments. As you know, currently, there is no convincing evidence showing that single-port approach is superior to multiport approach in terms of reducing postoperative pain. Further investigation is required. In addition, as you pointed, our study groups were unbalanced in the drain installation which is one of the factors influencing postoperative pain. Therefore, we admit the shortcomings of our study, and thus addressed in the discussion section for it as follows.

"In addition, although the series of nSIL-CBDE are our early experience, nSIL-CBDE significantly reduced the requirement for intravenous analgesic administration (P = 0.010) and the duration of hospitalization (P = 0.010). However, drain placement is one of the factors influencing postoperative pain [23], and nSIL-CBDE group lesser placed the drain (15% vs. 95%, P < 0.001). Therefore, further investigation is required to determine whether or not nSIL-CBDE has the potential to reduce postoperative pain."

9.(P9, L14)It is not "SPLS", is it "SILS"?

RESPONSE) SILS is right. We have corrected it.

10.(P11, L9)You have two conclusions. You should write only one conclusion.

RESPONSE) Please accept our apologies. We selected one conclusion.

11.(P11, L10)What is the CAS abbreviated?

RESPONSE) Sorry. We corrected this to “critical view of safety”.

12.(Table 1)There are no head of the table.

RESPONSE) We apologize for the typographical error. We complemented it.

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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