

Point-by-point Responses

September 20, 2023

Dear Editor and Reviewers,

Thank you for providing us opportunity to revise the manuscript which has improved the value of our manuscript. We have considered each point carefully and responded. The followings are our point by point responses. The changes are highlighted in the revised version of the manuscript.

The followings are our point-by-point responses:

Reviewer #1:

Comment# 1) Please explain your selection criteria on how you decided PCD v/s ETGF

Reply: Thank you for your decent comment. As this is a retrospective study, we selected patients who suffered from PFCs that was adjacent to the gastric wall treated with PCD or ETGF in our hospital. Whether PCD or ETGF mainly depend on patient's choice, as we explained them both procedure in details in advance.

Comment# 2) Why did you specifically select these patients for ETGF over EUS guided metal stent placement the results will be more meaningful if you have compared three groups- ETGF, EUS guided metal stent placement, PCD placement. I note your statement that metal stents are expensive and not widely available, but there are many series that reported metal stents in patients' cohorts from your region.

Reply: We appreciate your suggestion. Stent placement is easy to operate and has carried out in some area of China since 2013. And we have designed prospective randomized controlled study to compare ETGF and EUS guided metal stent placement one years ago and the number of cases on stent implantation is still small. Awkwardly, the stent had not been introduced into our hospital during the period of this study, so we preliminarily compared ETGF with PCD.

Comment# 3) Did these patients have similar techniques tried in other hospitals- in the sense if they were tried in other hospitals with PCD and you crossed them to ETGF or vice versa?

Reply: Yes, there were 5 patients in the ETGF group and 1 patient in the PCD group treated in other hospitals previously but failed. Uniformly, we grouped them according to the first intervention they received in our hospital. While preintervention may affect the clinical outcomes, so we excluded patients that preintervention was inconsistent with original treatment in our hospital (ETGF excluded 5 patients and PCD excluded 1 patient) and found that clinical success rate in ETGF was higher than PCD (28/29 vs 28/37, $p=0.045$).

Comment# 4) When you describe a relatively new technique in a case series, the

inclusion and exclusion criteria need to be more defined- as why you chose PCD v/s ETGF and why you didn't opt for EUS guided metal stent placement.

Reply: Yes, there were studies about EUS guided metal stent placement for drainage of PFCs in China. Awkwardly, due to economic and other factors, stent has not been introduced into our hospital during the research period.

As for inclusion and exclusion, we selected patients according to studies related to PCD and EUS guided stent placement published before.

Comment# 5) Do you have any estimate of total hospital visits, total interventions, total duration of hospital stay and cost effectiveness between two study groups?

Reply: Yes, we had collected those data initially. According to your suggestion, we found that there had no statistical difference about total hospital visits ($P=0.278$), duration of hospital stay ($p=0.177$), and total cost effectiveness ($p=0.955$) between two groups. But the interventions in PCD were more than that in ETGF ($p=0.003$). And the detail was added in the revised **table 1**.

In fact, average cost of ETGF was higher than PCD (1644\$ vs. 511\$ per operation). In other words, cost of ETGF is higher than PCD, while more intervention in PCD may bring about more cost.

Reviewer #2:

Comment# 1) Please consider the number of days from the onset of acute pancreatitis to the procedure, excluding pre-intervention cases in both groups.

Reply: Thank you for your comment. We initially collected data about the number of days from the onset of acute pancreatitis to the procedure and found that there was no statistical difference between within 4 weeks or more than 4weeks groups (7/28 vs. 13/37, $p=0.381$) excluding patients that preintervention was inconsistent with original treatment in our hospital. Taking your suggestion into consideration, we have provided detail about this in **table 1**.

Comment# 2) Please indicate the number of cases requiring necrosectomy after each treatment. Please perform multivariate analysis of factors associated with clinical success.

Reply: Thank for the reviewer's suggestion. There were 9 patients who failed after PCD and consequently transferred to necrosectomy. As for patients in ETGF, none of patient received surgical necrosectomy because we can operate endoscopic debridement.

As par your suggestion, we first take the treatment effect as the dependent variable, and the relevant factors (intervention measures, age, gender, size of lesion, number of days from the onset of acute pancreatitis to the intervention) as the independent variable, and conducted a univariate analysis. We found that age ($p=0.032$) and treatment method ($p=0.028$) influenced the treatment effect. Further multifactor logistic regression analysis showed that only treatment measure was independent influencing factors and patients in ETGF acquired higher clinical success ($p=0.032$).

Reviewer #3:

Comment# 1) is the definition of clinical success your own or internationally agreed? any other definitions exist?

Reply: We appreciate the reviewer for the good comment. Yes, there were studies about PCD and endoscopic drainage for the treatment of PFCs. We referred to related studies published before when defined clinical success.

Comment# 2) what is the size of PCD tubes. Were they retroperitoneal or intraperitoneal?

Reply: As mentioned in the manuscript, the caliber of drainage tube was 8Fr or 10Fr. In this study, majority of them were retroperitoneal.

Comment# 3) What is the size of nasocystic tube? Did you irrigate or lavage the nasocystic tube?

Reply: The sizes of nasocystic tube was 18Fr, which is the same as the diameter of normal gastric tube. We performed vacuum suction through the nasocystic tube after ETGF. Irrigate or lavage was operated during endoscopic operation.

Comment# 4) Any documentation of NG tube dislodgment?

Reply: Yes, there was one patient occurred tube dislodgment and we added the data on it in the table 2.

Comment# 5) How did you maintain nutrition with the ETGF? Did u give TPN? Did the PCD pts got enteral nutrition?

Reply: Thank you for pointing out this critical issue. Fasting and TPN is not necessary after ETGF, non-solid diet and subsequently normal diet was admitted after patient recover from anesthesia. We think diet was better than pancreatic enzymes and pathogenic microorganism inside the cavity of PFCs anyhow.

In addition, patients may tolerate with fasting if they were in acute phase of acute pancreatitis and TPN was given if necessary.

Patients received PCD under local anesthesia, so they got nutrition by oral feeding.

Comment# 6) How long do you give PPI prophylaxis?

Reply: We gave patients prophylaxis of PPI for 3 days after ETGF.

Once again, we thank the reviewers and editors for the comments. We have also polished the language by the editing service to improve readability of the manuscript, and look forward to hearing from you regarding our submission. We would be glad to respond to any further questions and comments that you may have.

Sincerely,
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