Name of journal: *World Journal of Gastrointestinal Surgery*

ESPS Manuscript NO: 10579

Columns: Case Report

Gastric necrosis: A late complication of nissen fundoplication

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ANSWERING REVIEWERS

1) Reviewed by 01115220: (sic) This is case report describing severe gastric necrosis as a presumed complication of increased intragastric pressure due to the combiation of a phyobezoar and a fundiplication. The case report is useful as it serves to highlight that fundoplication can have serious complications. There are several areas in the report that deserve some more attention. 1. There are inadequate references in the introduction. MOre references are required regarding both the gas-bloat syndrome and also the "other" cases of gastric necrrosis noted. Gas-bloat syndrome is really only seen as a complication of fundoplication yet the introduction makes no mention of this a post-surgical effect and seems to imply that this is a comdition seen away from surgery. 2. Some more details on the fundoplication are required. As the authors state later on, several elements of the surgery can influce the complication rate - hence was this a 360 degree wrap, how long was the wrap? 3. Why should this patient devlop a phytobezoar at the age of 63? Was a full medication history taken? Was there any suggestion of impaired oesophago-gastric motility pre-fundoplication? 4. Exactly what was the indication for fundoplication in this case? Is it possible that the gastrp-oesopheal reflux was always actually due to gastroparesis?

   We agree with the reviewer in the context where gas-bloat syndrome is seen, after antireflux surgery, so an amendment in the phrasing has been made. In regard to references, after many searches with expressions such as ("gastric necrosis"[Text Word]) AND "nissen"[Text Word] in PubMed and similar, very little articles can be found, and most of them are listed, as well as those in which a distal obstruction was involved. Gastric necrosis away from antireflux surgery was not a matter of our consideration in this particular case. More details of the surgical technique have been given as well as of the medication history and motility status prior to surgery. The indication of surgery was gastroesophagic reflux secondary to axial hiatal hernia with a DeMeester test over 14.72 and a slightly hypotonic lower esophageal sphincter as the only finding in the manometry. No gastroparesis or esophageal motility disorders were present at the time of surgery. This has also been added to the article.

   Many thanks for your comments.

2) Reviewed by 00734317: (sic) he authors analyzed a case of gastric necrosis due to gastric obstruction by a phytobezoar in a patient undergone a laparoscopic Nissen fundoplication(NF) seven months before. This complication of pylorus occlusion is very rare and interesting but in my opinion it is very difficult to identify the relationship

between previous laparoscopic surgery (Nissen fundoplication), pylorus occlusion and gastric necrosis. Gas bloat syndrome is a NF complication with a low incidence but its consequences might be considered with careful attention during postsurgical follow-up, especially during the first twelve months. Nevertheless in the reported case gastric necrosis seems to be due to pylorus occlusion rather than previous laparoscopic NF. Laparoscopic fundoplication may represent a risk factor (comorbid factor) only if completely occluding the passage from stomach to oesophagus. Analyzing this complication, the authors conclude that a short and floppy Nissen is safer than a long and tight wrap, which is a well known surgical principle in the antireflux surgery. The reported case is very rare and the paper is very interesting, resulting well conducted and well written. The title was really intriguing but less the content. Moreover literature review was not very accurate and I do not consider the paper suitable for being published in World Journal of Gastrointestinal Surgery.

Literature review is very subjective when writing about major surgical topics, as it is laparoscopic antireflux surgery, because of the abundance of articles. We just wanted to focus on similar cases and not in the technical approach or other issues, which are still controversial (division versus preservation of short gastric vessels, etc.), and literature in this context is rather seldom. Follow-up was carefully made and no alarm symptoms were detected, besides maybe eating habits, a point that we have highlighted in the revised text. Gastric necrosis following Nissen fundoplication as the only causing factor is more than difficult to see. Published cases always mention a distal obstruction in form of pylorus obstruction, small bowel adhesions, etc.

Many thanks for your comments.

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