

1. In METHODS section, its mentioned In our institution, the initial drainage technique for patients with hilar cholangiocarcinoma is usually unilateral endoscopic nasobiliary drainage (ENBD) to the future remnant liver lobe.[8] If ENBD is the preferred technique, why was EBS done in 33/118 patients as the initial drainage. It's not clearly defined as which patients were selected for ENBD or EBS? What was the criteria for allocating the patient to either group.

Answer

Thank you for the comments. As already mentioned in the manuscript, although ENBD is the preferred technique in preoperative drainage for hilar cholangiocarcinoma, selection for ENBD or EBS depended on each endoscopists. The patients were referred to our hospitals after biliary drainage was performed in several general hospitals. In deed, 64% of patients had already undergone biliary drainage at other hospitals.

According to the reviewer's comments, we added next sentences in the method section.

However, in other hospitals, the selection of initial drainage technique depended on each endoscopist.

We also added next sentences in the Result and added the number of patients who underwent initial drainage at our institution.

The initial drainage was performed at other hospitals in 75 patients.

2. While tabulating Complications as in Table-2, why the total complications are shown with out showing the complications in each group (ENBD and EBS). When you intend to compare the complications of two groups, isn't it necessary to show the parameters in both the groups.

Answer

Thank you for the comments. We revised Table 2 showing the complications in each group.

Reviewer 2544032

1. The manuscript presents a cohort of 118 patients with hilar cholangiocarcinoma, focusing on the best way to obtain biliary drainage. In a retrospective study, one or more complications were observed in 92 patients (78%), but endoscopic nasobiliary drainage (ENBD) is less dangerous than endoscopic biliary stent (EBS). The data also suggest that endoscopic papillotomy prevents post ERC pancreatitis. The data are interesting, and may even have some degree of external validity, ie – other tertiary HPB centers may come to similar results if the same preoperative workup is applied: “Preoperative drainage is mandatory to assess the surgical resectability and obtain pathological confirmation” (Introduction, upper paragraph – with ref 3 and 4, as evidence base). Several HPB-centers does not follow this path, but try to avoid preoperative drainage, if clinically possible. Peroperative verification of the carcinoma cannot be required, as even repeated endoscopic biopsies may end negative on atypical cells, even when the carcinoma is verified in the surgically resected specimen. In my opinion, the manuscript should be “turned around” (profoundly rewritten), and at least in the discussion, it should be underlined that the present high frequency of serious complications strongly support the avoidance of preoperative drainage. The recommendation of ENBD is supported by the data, and this is relevant for any reader, as several patients with hilar cholangiocarcinoma cannot avoid biliary drainage for numerous reasons.

Answer

Thank you for the interesting comments. I agree with the reviewer’s comments. As already mentioned in the manuscript, preoperative drainage was not considered mandatory in many institutions. However, in the clinical setting in Japan, surgery for hilar cholangiocarcinoma including major hepatectomy was not performed without preoperative verification and biliary drainage.

According to the reviewer’s comments, we added next sentences in the first paragraph of Discussion.

Our results showed that routine preoperative drainage for hilar cholangiocarcinoma should be avoided due to a high rate of complications.

We added next sentences in the second paragraph of Discussion.

Our study also demonstrated that routine preoperative drainage for hilar cholangiocarcinoma is not warranted.

We revised the final paragraph of Discussion as follows.

,so unplanned biliary drainage should be avoided.

Reviewer 50424

1. In this retrospective study, the authors end up into some conclusions, the majority of which are well known from previous studies. What is new is that according to their findings ENBD was a better approach and with lower complications. It is not clear whether ENBD placement was a permanent approach or a temporary action before the final biliary drainage. If ENBD was a definitive approach then quality of life should be examined because a stent is more easily accepted by the patients for long term use.

Answer

Thank you for the comments. In this study, we evaluated the complications in so-called 'temporary' drainage.

According to the reviewer's comments, we revised the method of Abstract as follows.

In total, 118 patients with hilar cholangiocarcinoma underwent endoscopic management (endoscopic nasobiliary drainage [ENBD] or endoscopic biliary stenting) as a temporary drainage in our institution between 2009 and 2014.

We also revised Conclusion of Abstract as follows.

ENBD should be selected as a temporary drainage method because of its low risk of complications.

We revised the study design as follows.

The prospectively collected endoscopy database at our department was searched for patients who underwent biliary drainage of hilar cholangiocarcinoma for temporary purpose from 2009 to 2014.

We revised the patient characteristics as follows.

During the study period, 125 patients underwent endoscopic biliary evaluation and drainage for temporary purpose at our institution.

We revised the first paragraph of Discussion as follows.

In this study, endoscopic biliary drainage of hilar cholangiocarcinoma for temporary purpose had a high morbidity rate.

We revised the last paragraph of Discussion as follows.

Endoscopic biliary drainage for temporary purpose in patients with hilar cholangiocarcinoma has a high morbidity rate.

2.