

# ANSWERING REVIEWERS

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**Gastric blunt traumatic injuries: A computed tomography grading classification**

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## **Reviewer 1**

Work is good, well designed. Results is accepted.

**R:** Thank you for your comments.

## **Reviewer 2**

The authors investigated gastric blunt traumatic injuries about CT classification. Some problems existed.

1. The language needs to be improved because of some grammar mistakes.

**R:** According to editing policy provided to revise English language by means of [www.aje.com](http://www.aje.com).

2. For such a classification of the CT imaging of gastric blunt traumatic injuries, the number of 32 patients is a little too few. More patients need to be involved for a better classification of the gastric blunt injury classification. However, this paper gave the first initial try in this aspect and had some values.

**R:** Thank you for your feedback. Actually 32 patients are few for such a classification, however gastric traumatic injuries are rare in clinical practice, for this reason they have been rarely reported in literature and still we lack a systematic a classification. We think this could be the beginning for a more structured and possibly multi-centric study, involving a greater number of patients.

3. Abstract: For an original research article, the abstract should be structural with Purpose, Materials and methods, Results and Conclusion. Please revise the abstract according to some already published research article.

**R:** Thank you for your comment. We structured the abstract following your indications.

4. Figures: There are some figures in the article. However, no citation of these figures was shown in the article. The citation of the figures were shown in the Table 4. This is not good. It is better to cite in the results as well.

**R:** We have cited figures in the text according to your indications.

5. Tables: For Table 1, there are more than 32 CT signs in the table and some patients may have more than one sign. It is better to point out which patients have one or over one signs. For Table 2, there are actually 33 abdominal associated lesions rather than 32 in 27 patients. Please check.

**R:** Thank you for your feedback. We corrected Table 1 and Table 2.

## **Reviewer 3**

1. The diagnosis of gastric injury was based on surgical findings in 22 patients, whereas for 10 patients the diagnosis was based on clinical and radiological findings. CT scan was performed in

all patients. What is the final diagnosis of these 10 patients and what grades are according to the classification system provided?

**R:** We retrospectively analyzed all patients that resulted to have a gastric traumatic injury collecting surgical and radiological reports to avoid to miss patients with minor lesions that didn't have lesions requiring surgery though that they had detectable gastric lesions on CT scan. Ten patients had only radiological diagnosis, in 1 there was gastric pneumatosis due to trauma, this radiological evident alteration was not associated to clinical conditions prompting a surgical intervention (grade 1 lesion); the other 9 patients had gastric wall thickening, 1 of them just on the external side, 1 on the inner side of stomach, of these nine patients 6 had peritoneal fluid, furthermore 5 of them had associated lesions requiring careful observation (1 mesentery, 3 spleen, 2 liver lesions). Six of these nine patients were grade 3 lesions, three were grade 2 lesions.

2. The diagnosis of gastric injury was based on surgical findings in 22 patients, whereas for 10 patients the diagnosis was based on clinical and radiological findings. CT scan was performed in all patients. As CT scanners were variable, the authors should clarify on which phase of contrast enhancement and on which criteria each imaging sign was assessed.

**R:** In all cases a basal phase was acquired and intravenous contrast material was administered with acquisition in the venous phase (70-90 seconds), a delayed scan was performed 4-5 min after the first scanning, without supplementary intravenous contrast material, in order to search or better define areas of active bleeding. The signs we evaluated were: luminal extravasation, discontinuity of gastric wall, free presence of peritoneal fluid and evaluation of its density, extraluminal air, pneumatosis, thickening and hematoma of gastric wall.