

July 6, 2013

Dear Editor and Reviewer of World Journal of Surgical Procedure,

Please find enclosed the edited manuscript in Word format (file number #3708)

Title: Operative Indications of Follicular Type Tumors, Based on Japanese Clinical Guidelines

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Name of Journal: World Journal of Surgical Procedure

ESPS Manuscript NO: #3708

The manuscript has been improved according to the suggestions of reviewer
1. Format has been updated

2. Revision has been made according to the suggestions of reviewer

(1) It will be more interesting if the authors show the results in table

According to the reviewers suggestion, we summarized the final pathological diagnosis and the results of preoperative examinations in Table 1 and 2, and inserted the sentence to page. 6, line 2-3 as follows.

The final pathological diagnosis and the results of preoperative examinations were summarized in Table 1 and 2.

We also attached Table 1 and 2 to page 13, 14 in the manuscript.

(2) The conclusion has to be rewritten

According to the reviewers suggestion, we rewrote the discussion part, and inserted rewrote sentences to page 8-9 in discussion part.

page 8, line 7-13, page 8, line 16--page 9, line 4 as follows.

page 8, line 7-13

In this follicular tumor study, correct diagnostic rates of FNA and CT were relative high with 50-60% on the preoperative examinations.

When we compared these 2 examinations, true positive rate, both true negative rates were more than 50% together in FNA examination. On the other hand, the CT test identified true positive rate 18.2 %, and true negative rates 88.0 %.

So, we think that FNA is a reliable examination for distinguish malignant and benign follicular tumor than CT study,

line 16-- page 9, line 4

CQ 5 of the guidelines state that “physical findings that increase the possibility of malignant neoplasm in thyroid tumors include adhesion to tissues surrounding nodes, lymph node enlargement, vocal cord paralysis (hoarseness), dyspnea, dysphagia, coughing” and “especially in tumor size alone, nodes of ≥ 40 mm are a significant independent factor suggestive of malignancy” [1, 9-14]. In addition, when a tumor is follicular carcinoma, tumor size ≥ 40 mm become stage III in the TNM classification of UICC, and the chance of remote metastasis will be increased.

Surgery is thought to be indicated in that reason for the follicular tumors ≥ 40 mm, which can not deny the malignancy. [15, 16].

In our results, only 3 of 28 follicular tumors ≥ 40 mm in diameter were follicular carcinoma (10.7%), and 5 of 36 follicular tumors ≥ 30 mm that were suspected the malignancy by several preoperative examinations, were malignant tumors (13.9%). Concerning about papillary carcinoma, although the size of papillary carcinoma were less than 20 mm, 6 cases coexisted with follicular adenoma and adenomatous goiter ≥ 40 mm that were benign on postoperative pathological diagnosis.

As described above, the malignancy rate of follicular tumors ≥ 40 mm was not high. However, considering coexisting lesions such as papillary carcinoma with benign follicular tumors ≥ 40 mm, the malignant region was present in a total of 12 of 36 suspected tumor (33.3%). So, we concluded that surgery is thought to be indicated as stated in the guidelines

For SNB, such as follicular variant of papillary carcinoma that have a fairly high frequency of lymph node metastasis, the surgical procedure can be changed depending on lymph node metastasis status during surgery. So, SNB is thought to have a high likelihood of being useful [15,17].

(3) It has to be edited by an English native speaker for better flow
According to the reviewers suggestion, the manuscript was edited by English native speaker again.

3. References and typing were corrected

Thank you again for revising our paper in detail, and for publishing our manuscript in the World Journal of Surgical Procedure

Sincerely yours,

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