ANSWERING REVIEWERS

March 10, 2014

Dear Editor,

Please find enclosed the edited manuscript in Word format (file name: 9209-review.doc).

Title: Retrieval-balloon-assisted enterography for ERCP after Billroth II gastroenterostomy and Braun anastomosis

Author: Wen-guang Wu, Wen-jie Zhang, Jun Gu, Ming-ning Zhao, Ming Zhuang, Yi-jing Tao, Ying-bin Liu, Xue-feng Wang

Name of Journal: *World Journal of Gastroenterology*

ESPS Manuscript NO: 9209

The manuscript has been improved according to the suggestions of reviewers:
1 Format has been updated

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

(1) Reviewer #1: This procedure can be useful expecially when you know what surgical procedure were used

Author：Thank you for your good comprehension on our manuscript . Review the patient's previous surgery records is very important .The surgical records are essential to identify whether the efferent loop was made on the lesser or greater curvature of the stomach.Thank you.

(2)Reviewer #2: It was a pleasure to review the manuscript entitled "Use of retrieval-ballon-assisted enterography for successful ERCP in patients with Billroth II gastroenterostomy and Braun anastomosis". Authors described a new technique to improve the sucess rate of ERCP in such patients. The manuscript is well written and the results encourage the use of this technique. However I have somme minor comments : - The major challenge in these patients is the identification of the correct entrances to achieve the papilla of Vater. I agree with authors that we can use the the greater and lesser gastric curvature as markers to identify the efferent loop on the BII anastomosis. However, in the Braun anastomosis the identification of the middle entrance ? might be very difficult because the rotation of the endoscope can change the point of view (i e, middle entrance may be interpreted as lower or upper entrance depending on the rotation). In addition, it seems that the surgical records are essential to identify whether the efferent loop was made on the lesser or greater curvature of the stomach. - There are some redundant comments on the Discussion (repetition of was described on the Results section) - It should be discussed that this study was retrospective, reflecting the experience of a single-center and also that the reproductibility of this technique should be assessed in the future. Best Regards

Author：Thank you for your good comprehension on our manuscript. Only the middle entrance is eternal no matter what the endoscope rotation at the Braun anastomosis site. The other two entrances may be interpreted because the rotation of the endoscope can change the point of view.

Review the patient's previous surgery records is very important .If the previous surgery records do not specify the location of the efferent loop, we extend the duodenoscope along the greater curvature of the stomach until the gastrojejunal anastomosis is visible and then advance it through the "lower entrance" and along the jejunal loop until it reaches the 3 stomal openings at the site of the Braun anastomosis. We use a retrieval balloon catheter to

explore the middle limb, with injection of contrast into the loop, and then confirm whether the limb is a duodenal stump or not. If the middle limb into which the catheter was advanced is the distal jejunum rather than the duodenal stump, the duodenoscope should be retracted to the gastrojejunal anastomosis and then advanced through the “upper entrance,” along the limb, and then into the “middle entrance” at the site of the Braun anastomosis to reach the papilla of Vater.

The redundant comments on the Discussion had been deleted. Your precious advices on the Discussion have been reflected in our revised manuscript.

(3) Reviewer #3:Thank you for submitting your manuscript entitled "Use of retrieval-balloon-assisted enterography for successful ERCP in patients with Billroth II gastroenterostomy and Braun anastomosis" to the World Journal of Gastroenterology. This manuscript is a retrospective study and the sequel of a prior publication. The technique is very interesting and the results are very encouraging but it reflects only a single center experience. For this reason the results are not valid but It would be interesting to start a prospective study on this topic to valid the procedure. However, the study suggest a new therapeutic possibility to perform ERCP in patients with Billroth II that can be reproduced in other Centers and for this reason it could be published. Best regards M. Fabozzi, MD, PhD

Author：Thank you for your precious advices. A prospective study on this topic is ongoing, and your further attention is our motivation

(4)Reviewer #4: I have had the opportunity to review the article entitled "use of retrieval-balloon-assisted enterogradpy for successful ERCP in patients with Billroth II gastroenterostomy and Braun anastomoosis. The authors have included 109 patients with B-II and 20 with B-II + Braun anastomosis. The concluded that R-B-A enterography improve the ERCP therapeutic success rate in such patients. In my opinion the authors should perform some modifications to improve the quality of the paper: 1-B-II gastrectomy is common, but Braun anastomois is less common, so the authors should explain the definition of both techniques 2-Discusion have to be modified and reduced in extension to avoid redundant comments and obtain a better understanding a) Discusion should stars with the results of the main objective (R-B-A enterography improve the .....), and after the results from the literature b)The authors should clarify the different techniques to perform comparisons, and probable a table could be convenient

Author：Your precious advices on the Discussion have been reflected in our revised manuscript. Thank you. The optimal enterography route and technique for ERCP in patients who have Billroth II gastroenterostomy and Braun anastomosis were different from simple Billroth II. Billroth II gastroenterostomy and Braun anastomosis are mainly introduced in this paper. Techniques of Billroth II will be elaborated in our next paper, and thank you for your further attention.

(5)Reviewer #5: Nowadays, It might seem somewhat a provocation to submit an original article about ERCP in patients with gastroenterostomy. In fact it has been forecast that these kind of patients will be nearly non-existent he next decades. Nevertheless I think that this article should be published.

Its strong points are the accurate and self-explaining iconography and the tutorial style of the method section; furthermore the fact that this article reports one of the largest available series of patients with Braun anastomosis (BA) treated by ERCP (if I am not incorrect the largest series, including 30 patients was published by Hintze). The authors should be congratulated for their suggestion/review of some cleaver professional tricks potentially useful for the endoscopists approaching these patients.

I have some minor changes to suggest and some remarks to put in discussion:

1. I doubt that the high percentage of success reported by the authors in treating BA patients was only due to the use of the balloon-assisted enterography. The position of the duodenal stump is often visible on plain

X-ray, as depicted simply by the air we insufflate during examination. I am a little sceptic about the utility of the balloon in facilitating the advance of the scope, but I realize that this is only my opinion. On the other hand, I think that an even more important determinant of these good results was the rational approach suggested by the Authors to recognize and explore the right loop. They highlight in the method and discussion sections the importance of reach the BA via the efferent loop. I regret that no traces of this useful technical suggestion are reported in the abstract. A simple statement could be sufficient: for instance: "In the present retrospective study, we aimed to describe the results of a standard original approach to the Braun anastomosis, including also the use of retrieval-balloon..."

Author：Your precious advices on the Abstract have been reflected in our revised manuscript. Thank you.

2. Authors quoted several times the disappointing results in BA patients reported by Cicek at al. Hintze et al. reported a much better experience, comparable with results obtained in BII patients without BA. I think that Authors should be quote both these results and they should state that very different successful rates are reported for ERCP in BA patients. Furthermore, despite of the fact the Hintze did not describe how reach papilla in BA patients, it seems from Fig 1 in his article, that accessing it from the afferent loop was his standard approach. This point might be discussed. Authors should also considerate that anatomy may be vary also in BA patients, according to individual technical solutions preferred by the surgeon.

   Author：We are pleased to quote the work of Hintze et al. in our revised manuscript. Thank you. Accessing duodenoscope from the efferent loop, the rule of "middle entrance" at the site of the Braun anastomosis can be used. We use this rule to avoid into the wrong channel. We elaborated the optimal enterography route for patients with Billroth II gastroenterostomies and Braun anastomoses in previous report .Wen-Guang Wu, Jun Gu, Wen-Jie Zhang, Ming-Ning Zhao, Ming Zhuang, Yi-Jing Tao, Ying-Bin Liu, Xue-Feng Wang. ERCP for patients who have undergone Billroth Ⅱ gastroenterostomy and Braun anastomosis. World J Gastroenterol 2014; 20(2): 607-610.[PMID: 24574733 DOI: 10.3748/wjg.v20.i2.607]

3. It is not clear for me what success rate of enterography means. To improve quick comparison of the present and other series by others contributors, I suggest using a more widely accepted. Authors are invited to report their success in reaching the papilla, in cannulation and the overall clinical success of the procedure.

   Author：Your precious advices on the terminology have been reflected in our revised manuscript. The success rate of enterography means the success in reaching the papilla, and the cannulation success is the same as the overall clinical success in our study. Thank you.

4. Authors focus their attention on their results in BA patients. There are few doubts that this is the most interesting part of their experience. Nevertheless if the Authors decide to report their complete experience, findings about both parts of their series should be shown with the same amount of details. I suggest to substitute Table 1, with another resuming concisely the characteristics and the findings of the patients in the two groups of BII patients (with and without BA). Alternatively they might consider the radical solution of reporting only findings in BA patients.

   Author：We focus our attention on BA patients, and how to reach the papilla is the main purpose of this

study. We believe that Table 1 is irreplaceable.Thank you for your advice.

5. Although the focus is on how to reach the papilla, some more technical details are welcome (again to improve comparison with other experience): how did they perform sphincterotomy? How many endoscopic sessions were needed to complete the treatment? Did the Authors use a frontal-viewing instrument in some difficult cases? How long was the procedural time? In particular I wonder whether air or carbon bi-oxide was insufflated during the procedure and whether the Authors consider carbon bi-oxide particularly useful in this setting.

   Author：We focus our attention on BA patients, and how to reach the papilla is the main purpose of this study. Thank you for your advice. Some more technical details you concerned will be reported in further study, and thank you for your further attention.

6. I suggest to quote too: Costamagna et al. Digestive and Liver Disease, 2006 [Abs]; Ricci et, Gastrointest Endosc 1989.

   Author：We are pleased to quote those works in our revised manuscript. Thank you.

3 References and typesetting were corrected

Thank you again for publishing our manuscript in the *World Journal of Gastroenterology*.

Sincerely yours,

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