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PEER-REVIEW REPORT

Name of journal: World Journal of Gastroenterology

Manuscript NO: 44882

Title: Role of abdominal ultrasound for the surveillance follow-up of pancreatic cystic neoplasms: A cost-effective safe alternative to the routine use of magnetic resonance imaging

Reviewer's code: 03706560

Reviewer's country: Brazil

Science editor: Ruo-Yu Ma

Date sent for review: 2018-12-13

Date reviewed: 2018-12-14

Review time: 14 Hours, 1 Day

SCIENTIFIC QUALITY	LANGUAGE QUALITY	CONCLUSION	PEER-REVIEWER STATEMENTS
[ ] Grade A: Excellent	[ ] Grade A: Priority publishing	[ ] Accept (High priority)	Peer-Review:
[ ] Grade B: Very good	[ ] Grade B: Minor language polishing	[ ] Accept (General priority)	[Y] Anonymous
[Y] Grade C: Good	[Y] Grade C: A great deal of language polishing	[ ] Minor revision	[ ] Onymous
[ ] Grade D: Fair	[ ] Grade D: Rejection	[Y] Major revision	Peer-reviewer's expertise on the topic of the manuscript:
[ ] Grade E: Do not publish		[ ] Rejection	[Y] Advanced
			[ ] General
			[ ] No expertise
			Conflicts-of-Interest:
			[ ] Yes
			[Y] No

SPECIFIC COMMENTS TO AUTHORS

First, I want to congratulate the author for the manuscript. I read it with great interesting. The study is well conducted, however, some concerns needs to be adressed: English

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language needs major revision from an US native speaker with experience with pancreas diseases and imaging tests. Introduction: - What about EUS? Authors should at least cite this method which is essential on the follow-up of PCN. Methods: - This section is confusing. - First authors report: "US scan every six months for the first year and then, for stable disease, annually from the second to the fifth year" and them "A planned MRI was routinely executed every two years for static disease or because of suspicious changes observed on US. Abdominal US was always performed just before the planned routine MRI.". How the abdominal US was ALWAYS performed just before MRI if MIR is just performed every 2 years? - Do you really have consent for abdominal US? - Did you exclude patients that used Contrast enhanced? Does this procedures add costs? Results: - Table 1: please specify where were the other lesions. How many lesions were at uncinate process and tail? - Wirsung medium diameter was 2.6. Where the Wirsung was measure? Head or Body? - In the first case that the patient went to surgery, did you not perform an EUS before? Why? - "Overall, the US used in the PCN surveillance showed a sensitivity of 72%, negative predictive value of 94%, an accuracy of 95% and an AUC of a ROC curve of 86% (confidence interval 77 – 94 %; $p<0.001$) (Figure 2)". This results are considering MRI as a gold standard? - You need to consider the value that you spent and not the value that you should spent if any of the patients needs MRI. Change figure 3 for the second and real analysis. Discussion: - The discussion is great showing that the US follow-up program can be used just in a selected group and with a experience US group. - I just believe that authors should discuss about EUS. Otherwise, it appears that just US and MRI have a role in the management of PCN. - Limitations: Perfect. Well done. Conclusion: Please add US done by an expert physician References: - References are updated. It's good.

INITIAL REVIEW OF THE MANUSCRIPT

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PEER-REVIEW REPORT

Name of journal: World Journal of Gastroenterology

Manuscript NO: 44882

Title: Role of abdominal ultrasound for the surveillance follow-up of pancreatic cystic neoplasms: A cost-effective safe alternative to the routine use of magnetic resonance imaging

Reviewer's code: 02952159

Reviewer's country: Germany

Science editor: Ruo-Yu Ma

Date sent for review: 2018-12-13

Date reviewed: 2018-12-19

Review time: 16 Hours, 6 Days

SCIENTIFIC QUALITY	LANGUAGE QUALITY	CONCLUSION	PEER-REVIEWER STATEMENTS
[ ] Grade A: Excellent	[ ] Grade A: Priority publishing	[ ] Accept (High priority)	Peer-Review:
[Y] Grade B: Very good	[Y] Grade B: Minor language polishing	[ ] Accept (General priority)	[Y] Anonymous
[ ] Grade C: Good	[ ] Grade C: A great deal of language polishing	[ ] Minor revision	[ ] Onymous
[ ] Grade D: Fair	[ ] Grade D: Rejection	[Y] Major revision	Peer-reviewer's expertise on the topic of the manuscript:
[ ] Grade E: Do not publish		[ ] Rejection	[Y] Advanced
			[ ] General
			[ ] No expertise
			Conflicts-of-Interest:
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SPECIFIC COMMENTS TO AUTHORS

Comments Authors reported on their clinical experience in terms of safety, feasibility and cost efficacy of a follow-up strategy based on abdominal ultrasound (US) with

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restricting use of Magnetic Resonance Imaging (MRI) every two years and suspicious cases. They concluded that in selected patients with PCN without absolute or relative surgical criteria, abdominal US, could be a safe complementary to MRI, delaying and reducing the numbers of second level examinations and therefore reducing the costs of surveillance. Abstract: 1. What kind of pancreatic cystic neoplasms (PCN) are considered as without absolute or relative criteria for surgical intervention at the time of diagnosis? Please clarify. 2. 'Mean follow-up period was 25.1 months (±18.2)'. What is the end point of follow-up period? Please clarify. 3. What kind of PCN are defined as 'increased number of the PCN'? Background: 1. Authors mentioned 'PCN are encountered in as many as 3% of abdominal CT examinations and up to 20 - 45% of MRI scans', why the MRI detection rates are (too) much higher than CT in PCN? Please clarify if there is a bias beyond better sensitivity for cysts using MRI? 2. 'The most common PCN are pre-cancerous lesions' (is this really true?), why these patients should still be considered as 'PCN without absolute or relative surgical criteria'? 3. Authors want to use 'trans-abdominal ultrasound (US) in monitoring PCN'. However, according to the European evidence-based guidelines on pancreatic cystic neoplasms, 'mural nodes < 5 mm are relative indications for surgical intervention'. Could trans-abdominal ultrasound (TUS) detect mural nodes < 5 mm? How about difficult patients? Please clarify in how many patients the pancreas can be sufficiently evaluated using TUS. 4. Nowadays, CEUS has been gradually recognized as an easy and comparable imaging technique in diagnosis of pancreatic lesions, why do authors still use the conventional trans-abdominal ultrasound (US) technique? Please clarify. 5. Please clarify the role of Endoscopic Ultrasound. Methods: 1. What kinds of 'PCN without absolute or relative indication to surgery' were included in their current study and what are the criteria? 2. What is the gold standard for diagnosis in their current study? 3. What are the ultrasound diagnostic standard criteria? 4. How to differentiate malignant from benign

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PCN lesions by ultrasound? Please list criteria and cite studies or US guidelines. 5. All patients underwent to a US 'every six month' annually. However, a MRI scan was routinely performed every 'two years'. The time intervals of US and MRI are different, how to make the results comparable? 6. How to define 'stable disease' or 'static disease'? 7. 'The reasons for shortening the imaging interval and advance the MRI consisted of dilatation of main duct of more than 50%, increased size of the cyst 2 mm'. Could (can) MRI detect 'increased size of the cyst 2 mm'? Please clarify the accuracy of the methods to show changes of size. 8. How about patients with difficult PCN lesion on ultrasound? Such as those located on the pancreatic tail? Results: 1. 'Two hundred patients with 261 PCN'. How many patients have single lesions and how many have multiple lesions? Are those multiple lesions always the same? 2. 'Overall, the US used in the PCN surveillance showed a sensitivity of 72%, negative predictive value of 94%, an accuracy of 95% and an AUC of a ROC curve of 86%'. What are the US diagnostic standard mentioned here? How about that of MRI? Discussion 1. Why did authors only consider 'US can be considered an alternative method to follow PCN'? How about EUS? CE-(E)US? Please clarify. 2. What is the definition of 'target US'? Guided by MRI or CT? 3. What are the ultrasound features of 'the development of new cysts and small mural nodes'? Please explain with certain figures. 4. What kind of 'small new PCN' could be detected or diagnosed by conventional ultrasound? 5. What might be the potential risk or disadvantages of 'delaying the routine MRI imaging'? Please discuss in details. Figures 1. Figure 2 – 'ROC analysis showed the accuracy of US', please indicate the time of ultrasound in this figure. Did they only include MRI performed at 2 year after diagnosis?

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