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ESPS Peer-review Report
Name of Journal: World Journal of Gastroenterology
ESPS Manuscript NO: 6418
Title: ELECTIVE OPERATION AFTER ACUTE COMPLICATED DIVERTICULITIS IS IT STILL MANDATORY?
Reviewer code: 02455429
Science editor: Cui, Xue-Mei
Date sent for review: 2013-10-18 14:53
Date reviewed: 2013-10-21 00:08

CLASSIFICATION	LANGUAGE EVALUATION	RECOMMENDATION	CONCLUSION
[ ] Grade A (Excellent)	[ ] Grade A: Priority Publishing	Google Search:	[ ] Accept
[ ] Grade B (Very good)	[Y] Grade B: minor language polishing	[ ] Existed	[ ] High priority for publication
[ ] Grade C (Good)	[ ] Grade C: a great deal of language polishing	[ ] No records	[ ]Rejection
[Y] Grade D (Fair)	[ ] Grade D: rejected	BPG Search:	[Y] Minor revision
[ ] Grade E (Poor)		[ ] Existed	[ ] Major revision
		[ ] No records	

COMMENTS TO AUTHORS
This study shows that in patients with complicated acute diverticulitis conservative management is the "possible" approach in over 70% of cases. This is a nice result based on a retrospective design that could lead to a superselection of patients with the best prognosis. This limit should be discussed in the paper e the conclusions should be softer. Some discrepancies are evident between the results paragraph and the synoptic table , so please check the numbers.

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Name of Journal: World Journal of Gastroenterology
ESPS Manuscript NO: 6418
Title: ELECTIVE OPERATION AFTER ACUTE COMPLICATED DIVERTICULITIS IS IT STILL MANDATORY?
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Science editor: Cui, Xue-Mei
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Date reviewed: 2013-11-18 20:51

CLASSIFICATION	LANGUAGE EVALUATION	RECOMMENDATION	CONCLUSION
[ ] Grade A (Excellent)	[ ] Grade A: Priority Publishing	Google Search:	[ ] Accept
[ ] Grade B (Very good)	[Y] Grade B: minor language polishing	[ ] Existed	[ ] High priority for publication
[ ] Grade C (Good)	[ ] Grade C: a great deal of language polishing	[ ] No records	[Y]Rejection
[Y] Grade D (Fair)	[ ] Grade D: rejected	BPG Search:	[ ] Minor revision
[ ] Grade E (Poor)		[ ] Existed	[ ] Major revision
		[ ] No records	

COMMENTS TO AUTHORS
ESPS: 6418 "ELECTIVE OPERATION AFTER ACUTE COMPLICATED DIVERTICULITIS IS IT STILL MANDATORY?" The authors examine the question of nonoperative versus operative treatment of complicated diverticulitis (CD) and follow a cohort of CD patients following their initial presentation. They found that 71% of patients did not require further intervention and than non required an urgent Hartmann's procedure following initial presentation. The paper is a relevant one for the World Journal of Gastroenterology. The major limitation of this paper, however, is that it is unclear that these are truly a cohort of complicated diverticulitis patients, since the definition is at best symptomatic diverticulitis with only 9 patients needing drainage. The authors include CD treated only with antibiotics, which is the vast majority of this cohort. This paper would benefit tremendously from editing by an English technical writer as the current manuscript has many issues with truncated sentences, as well as poor and incorrect word choices. The results are lacking overall, as only a figure of the patient cohort is provided. The results should be summarized in table(s), especially the characteristics of the patients, their disease, as well as the Univariate analysis of predictive factors of needing elective operative intervention, including N and %, along with p-Values. The authors do not give substantive information about patient co-morbidities. The authors mention the Gaertner et al. article. The main difference between this cohort and the Gaertner cohort is that the Gaertner cohort contained patients who received a percutaneous drain for CD and an operation was considered high-risk, and the cohort did not get an operation because of comorbidities (ie., cardiac status or immunosuppression). This cohort, in contrast, follows a cohort with unclear co-morbidities. A survival curve would be needed to really understand the

natural history of this cohort (with censoring for those lost to follow-up).

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Name of Journal: World Journal of Gastroenterology
ESPS Manuscript NO: 6418
Title: ELECTIVE OPERATION AFTER ACUTE COMPLICATED DIVERTICULITIS IS IT STILL MANDATORY?
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Science editor: Cui, Xue-Mei
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CLASSIFICATION	LANGUAGE EVALUATION	RECOMMENDATION	CONCLUSION
[ ] Grade A (Excellent)	[Y] Grade A: Priority Publishing	Google Search:	[ ] Accept
[ ] Grade B (Very good)	[ ] Grade B: minor language polishing	[ ] Existed	[Y] High priority for publication
[Y] Grade C (Good)	[ ] Grade C: a great deal of language polishing	[ ] No records	
[ ] Grade D (Fair)		BPG Search:	[ ]Rejection
[ ] Grade E (Poor)	[ ] Grade D: rejected	[ ] Existed	[ ] Minor revision
		[ ] No records	[ ] Major revision

COMMENTS TO AUTHORS

COMMENTS Abstract - Results, line 4: "The 84 non-operated..." If I'm not wrong, it should be 81 instead of 84. What does this paper add to the literature? - Line 3: "This approach has an impact for the patient but also for society". I wonder if the authors are thinking about "society" or about "health care system" Methods: - Last paragraph, line 2: I wonder if the family physician may have accurate data about abdominal pain Results: - According to literature, more than 75% of patients with diverticulitis are uncomplicated. Thus, I'm surprised that in this series, only 43% (143 patients) had an uncomplicated diverticulitis while 57% were complicated. Moreover, 22% of patients needed emergent surgery, which is a really high percentage, compared to the published series. If the numbers are correct, this is something that the authors might be interested to analyse. - In the Methods chapter, the authors state that patients in whom nonoperative management failed, underwent repeat abdominal CT before surgery. However, the authors do not provide any information about the CT findings of the 9 patients that required an operation in the Results chapter. - Another surprising fact to consider is that the main indication for surgery was generalized peritonitis and the mean time to emergent surgery was 8.4 days (2-24). It is not very common that patients have a generalized peritonitis after so many days, instead of an abscess or a plastron. - One patient died after a Hartmann procedure. In my opinion, it would be better to know the cause of death rather than the age of the patient Discussion: - Paragraph 11, line 2: 71% of cases are the percentage of patients with complicated diverticulitis that were managed only with medical treatment. It is not clear enough (the same as in the abstract) where the "71%" comes from, as there is no reference in the Results chapter. It would be preferable to add a short comment in the Results

chapter to make it easier to understand. - If the authors want to comment if elective surgery would be advised in high-risk patients, then important references should be included. Hwang et al (Dis Colon Rect 2010) concluded that, due to the lack of evidence, a prophylactic sigmoidectomy is not recommended in immunosuppressed patients after one episode of diverticulitis. Klarenbeek et al (Ann Surg 2010) suggested that high-risk patients should be offered an elective sigmoid resection. Biondo et al (Am J Surg 2012) reported that the overall risk of recurrence rate was similar in immunosuppressed and nonimmunosuppressed patients and they suggested that immunosuppressed patients need not to be advised to have an elective sigmoidectomy. MINOR COMMENTS Methods: - Last paragraph, line 2: "may" is misspelled Discussion - Line 3: "although" is misspelled

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CLASSIFICATION	LANGUAGE EVALUATION	RECOMMENDATION	CONCLUSION
[ ] Grade A (Excellent)	[ ] Grade A: Priority Publishing	Google Search:	[ ] Accept
[ ] Grade B (Very good)	[Y] Grade B: minor language polishing	[ ] Existed	[ ] High priority for publication
[ ] Grade C (Good)	[ ] Grade C: a great deal of language polishing	[ ] No records	[Y]Rejection
[Y] Grade D (Fair)	[ ] Grade D: rejected	BPG Search:	[ ] Minor revision
[ ] Grade E (Poor)		[ ] Existed	[ ] Major revision
		[ ] No records	

COMMENTS TO AUTHORS
This retrospective study assessed the rate of recurrence and the patterns of complications of Complicated diverticulitis after non-operative managing. Authors found that a conservative approach is feasible and safe in up to 70% of cases, and advice that surgical treatment have to be advised only in patients with complications (fistula, symptomatic stenosis). The final conclusions of this study are not completely original, since several studies found recently that complicated diverticulitis can be managed nonoperatively at first. Moreover, the importance of these results are limited by the retrospective design. Several weaknesses may be detected through the manuscript: METHODS 1. An heterogeneous population was enrolled (ranging from small abscesses to free peritoneal perforation): characteristic of each subgroup have to be described. 2. Which vital signs were assessed? Blood pressure and fever? 3. Which was the dose of cephalosporins and metronidazole? 4. For how many days antibiotics were provided? 5. Which oral antibiotics were prescribed at the end of intravenous therapy? At which dose? 6. SIRS criteria have to be described for non-surgeons readers. RESULTS 1. Evaluation according to each CD subgroup has to be performed and described in a separate table. For example, what happened in patients with free air compared to those with pelvic abscesses? 2. Was an antibiotic treatment prescribed at discharging, according to guidelines? 3. Was a long-lasting maintaining treatment prescribed in those patients (e.g. cyclic antibiotic and/or probiotics and/or mesalamine)? 4. Recurrence definition is unclear. In Methods, it is defined as “recurrence of symptoms more than 30 days after discharge”. In this way, how the authors assessed the occurrence of complications during the follow-up? 5. Authors describe that 16% of patients managed nonoperatively had recurrent abdominal pain: how authors consider

those patients? Recurrence of symptoms may be due persisting colonic motility alteration or due to persisting low-grade inflammation causing recurrence of diverticulitis: how authors differentiate among these two entities to define diverticulitis recurrence? 5. What happened in patients with recurrence of symptoms? Were reassessed in order to define a medical or surgical treatment or what?

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CLASSIFICATION	LANGUAGE EVALUATION	RECOMMENDATION	CONCLUSION
[ ] Grade A (Excellent)	[ ] Grade A: Priority Publishing	Google Search:	[ ] Accept
[ ] Grade B (Very good)	[ ] Grade B: minor language polishing	[ ] Existed	[ ] High priority for publication
[ ] Grade C (Good)	[Y] Grade C: a great deal of language polishing	[ ] No records	[ ]Rejection
[Y] Grade D (Fair)	[ ] Grade D: rejected	BPG Search:	[ ] Minor revision
[ ] Grade E (Poor)		[ ] Existed	[Y] Major revision
		[ ] No records	

COMMENTS TO AUTHORS
The authors provide a retrospective evaluation of non operative management following complicated diverticulitis. This is a relevant question now more patients are treated non resectionally with antibiotics, percutaneous drainage and laparoscopic lavage. It is a limitation that laparoscopic lavage was not included as a treatment option and the low number of percutaneous drainage raises questions regarding the presence of abscesses or free air in all patients. Title: Reflects the hypothesis well, but could be written better Introduction and hypothesis: Hypothesis not clearly stated Design and methods: Inclusion and treatment protocol are clear. Outcomes could be stated more clearly with better definitions. The inclusion of complicated diverticulitis (CD) only does not correlate with a percutaneous drainage rate of <10%. The authors need to provide more details on classification and treatment protocol to clarify this. Is this a complete cohort or are there any inclusion and exclusion criteria other than the excluded patients with uncomplicated diverticulitis and those with an indication for acute surgery? Quality of presentation of results: Results are poorly presented overall. Numbers of patients in the figure do not match the results. The results section is in need of some tables to provide more information regarding patient's characteristics (comorbidity, Hinchey classification) and provide better overview of the results. How can the range for time to intervention be up to 24 days, but the range for hospital stay up to 21 days? Are these interquartile ranges? What is the interval until elective sigmoid resection? Did any acute interventions occur? What was the cause of death of the 86 year old following Hartmann? How many patients had a colonoscopy? Provide p-values for all relevant variables. How can you determine if free air and abscess are associated with the need of surgery if these were the inclusion criteria? Or do

the authors mean the association between severity of Hinchey stage and need for elective surgery? This can never be a fair analysis as those with worse classification are more likely to have had emergency surgery already. Early years are associated with a higher risk of elective surgery; can you clarify this by showing the indications for the elective resections in each time period? (Are all 11 elective resection without accurate indication performed in those years?) The authors do discuss the differences in success rate between mesocolic and pelvic abscesses in the discussion section but do not provide this subgroup data in their own cohort. The size and numbers of abscesses is missing. The authors define patient groups who could benefit from prophylactic sigmoid resection in the discussion but do not provide information whether these groups were included in their own cohort. Appropriateness of interpretation: Authors consider their results preliminary to future research on targeting subgroups, but they did not provide any details on patients that would belong to those possible subgroups in their results. The authors recommend deciding for elective surgery on a case-by-case basis, in accordance to current guidelines but do not acknowledge this. What is the point to state "rare" patients having recurrences? This is not appropriate for 7%. Length and appropriateness of discussion: Discussion does not start with answer to the research question. The first two sentences of the discussion do not contribute to the following part. The included references here are inappropriate; there is no need to reference one author four times for one statement regarding controversy (different opinions would be more useful). Limitations need more description and discussion. Conclusion: The first sentence is poorly stated. Why "short-term" with a follow up of 32 months? Do the authors mean a larger cohort or a longer follow up? Appropriate references: Especially in the first

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CLASSIFICATION	LANGUAGE EVALUATION	RECOMMENDATION	CONCLUSION
[ ] Grade A (Excellent)	[ ] Grade A: Priority Publishing	Google Search:	[ ] Accept
[ ] Grade B (Very good)	[ ] Grade B: minor language polishing	[ ] Existed	[ ] High priority for publication
[Y] Grade C (Good)	[Y] Grade C: a great deal of language polishing	[ ] No records	[ ]Rejection
[ ] Grade D (Fair)	[ ] Grade D: rejected	BPG Search:	[ ] Minor revision
[ ] Grade E (Poor)		[ ] Existed	[Y] Major revision
		[ ] No records	

COMMENTS TO AUTHORS
The subject is interesting,but the paper is not so fluent and well-written. It needs revision. The total number of patients differs in text and Figure (331 vs 335. Methods: is it population-based or referals from other hospitals? why is not CRP used instead if Leukocytosis? Results: put data in Tables! Difficult to read all these figures The indications for acute and elective surgery should be clear (not left to discretion of the treating surgeon) The univariate analysis is unclear: two periods are sign. "before 2008 and before 2010" Díscussion: Start by presenting the data from the audit. Then discuss the data and other studies. "Five previous studies have examined..." just three are presented. What is ment by inaugural?