Author's response to reviews

Title: Duodenal carcinoma at the ligament of Treitz. A molecular and clinical perspective.

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Authors' Response to Reviewers

We would like to thank both of the reviewers for taking the time to review our manuscript and providing constructive criticisms. At this time we will address the issues raised with our manuscript. Provided is a point to point response by our author team to the reviewers.

Reviewer #1

In response to Dr. Patrick G. Brady

1. Thank you for pointing out that Gardner's Syndrome, a variant of FAP. We have now addressed this issue by including in the introduction/background a list of the hereditary syndromes that predispose someone to small bowel neoplasms such as hereditary nonpolyposis colorectal cancer (HNPCC), Muir–Torre syndrome, Peutz-Jeghers, juvenile polyposis syndrome, FAP, and FAP's variants.

2. The reviewer is very correct. We have revised the section on the APC gene mutations according to the specific comments.

3. In regards to the recommendations of colonoscopy for patients with duodenal adenomas and carcinomas, we have added this to the discussion per your recommendations.

4. The addition of Celiac's disease in the background section as a small bowel tumor risk factor has been added with reference.

5. We have incorporated your excellent suggestion regarding balloon assisted enteroscopy in the discussion and have cited recent references comparing both single and double balloon enteroscopy.

Discretionary Revisions
According to the reviewer’s suggestion we have eliminated one figure.
Reviewer #2
In response to Dr. Adriana Safatle- Ribeiro

1. We agree with Dr. Safatle-Riberiro that obscure GI bleeding is an indication for capsule and balloon assisted enteroscopy, however as seen in this case push enteroscopy was able to make the diagnosis. However as stated in discussion the next logical step would have indeed been balloon assisted enteroscopy.

2. In regards to the analysis of genetic markers in small bowel neoplasms at our institution EGF staining was standard protocol for adenocarcinoma. However as a community based hospital TGFα and VGEF staining is not routinely done. Due to the fact that the patient has refused any further evaluation or chemotherapy staining for any genetic markers may not change clinical management at this point. Unfortunately the patient has refused any further workup or treatment and has been non compliant with recommendations or appointments for consultation.

3. The tumor was resected en bloc and the small bowel brought back together via a primary Gambee anastomosis. This has been mentioned in the discussion per your suggestion. We have also added that the information that the tumor was resected with clear margins and two (2) lymph nodes were removed during the procedure.

4. The discussion was shortened according to the reviewer’s suggestion.