Author's response to reviews

Title: Laparoscopy-assisted posterior low anterior resection of rectal cancer

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Author's response to reviews:

July 11, 2014
Tonilynn Manibo,
Journal Editorial Office BioMed Central
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on behalf of Dr Andrew Beggs
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RE: MS: 6073791471259896
Laparoscopy-assisted posterior low anterior resection of rectal cancer
Dear Dr. Beggs,

My colleagues and I are re-submitting our manuscript entitled: “Laparoscopy-assisted posterior low anterior resection of rectal cancer”.

We sincerely thank the reviewers for their comments and we feel we have addressed their concerns in a point by point manner. The revised text is highlighted in yellow. We are grateful to the reviewers as we feel that our manuscript is much improved because of their input. The data we have presented is true and reliable and has not been published in any journal.

We hope you find our revised manuscript acceptable for publication in your journal.

Yours sincerely,
Yan-Fu Du

Reviewer's report #1
Title: Laparoscopy-assisted posterior low anterior resection of rectal cancer
The authors should be congratulated for reporting their technique in a challenging group of patients. My suggestions are to improve clarity for the generalist reader, as this is a technique paper for the super-specialised pelvic surgeon.

Minor compulsory changes:

1. Introduction – is long and rambling. The authors need to get to their point much faster, and how they will address current controversies.

Author’s response: We thank the reviewer for his/her comments. We have revised the Introduction section, as follows:

“Low rectal cancer is a relatively common malignant disease with high morbidity and mortality rates.[1,2] Globally, low anterior resection has been the mainstay of surgical therapy for rectal cancer since the 1970’s. Despite the best efforts of experienced surgeons, 5-year survival rates have ranged from 27% to 42%.[3] This conventional technique has also been associated with a high risk of damage to the autonomic pelvic nerve plexus, resulting in sexual and bladder dysfunction.[3]

The introduction of TME, [4,5] first described by Heald et al. in 1982,[6] was a milestone in the treatment of rectal cancer.[7] Many studies, however, have shown that TME is a technically demanding procedure that requires excision of the intact mesorectum, in the narrow space of the pelvic cavity.[3,8-10]

In addition to TME, rapid advancements in laparoscopic technique have allowed for the laparoscopic resection of rectal cancer.[5,11-14] with improved postoperative recovery and earlier return to full activity. However, [5,15-17] rectal cancer has been excluded from most trials of laparoscopic resection of the large bowel because of the technical complexity of the procedure.[17-23] The anatomic position of the rectum makes access more difficult, and TME, with preservation of the autonomic nerves and the sphincter apparatus (important to maintain bladder control, continence, and sexual function),[18,24] is associated with a considerably higher rate of complications than that of colonic surgery. This is especially true if the surgeon does not have sufficient experience in open TME and advanced laparoscopic surgery, although the MRC CLASSIC trial has shown that the oncological outcomes are similar to open.[25]

In addition, for middle and low rectal cancer, especially in overweight patients or patients with a narrow pelvis, it is difficult to treat the bowel at the distal end of a tumor. Thus, for middle and low rectal cancer, especially for patients with a lower tumor edge at 2-5 cm from the dentate line, laparoscopy-assisted posterior low anterior resection (LAR) of rectal cancers is performed, although the procedure remains controversial. T3/T4 tumors would still be dealt with in the normal way.

Because of these issues, we reported our surgical experience with laparoscopy-assisted posterior LAR of rectal cancer cases that had a tumor edge...
within 2 to 5 cm from the dentate line. The term “posterior LAR” refers to the low anterior resection for rectal carcinoma completed via the posterior perineum. The term “posterior” (i.e., posterior approach) refers to the approach of posterior perineoplasty.”


2. Methods

Selection bias – the authors do make clear their selection of patients for this specific procedure. The following information is needed:

a. are these consecutive patients

Author’s response: We thank the reviewer for his/her comments. We have revised the 2nd paragraph of the Methods subsection Clinical data, as follows:

“Patients were included discontinuously from September 2009 to February 2012.”

b. how many patients underwent surgery for rectal cancer in total over the corresponding period.

Author’s response: We thank the reviewer for his/her comments. We have revised the 2nd paragraph of the Methods subsection Clinical data, as follows:

“…During this period, a total of 223 cases received rectal cancer surgery, 96 cases received laparotomy, and 127 cases received laparoscopic surgery in our hospital, of which 13 cases were reported.”

c. Also, what did these patients receive surgically? (i.e. open v lap assisted v the 13 in this report).

Author’s response: We thank the reviewer for his/her comments. We have revised the 2nd paragraph of the Methods subsection Clinical data, as follows:

“…From June 2011 to June 2013, all 13 cases of rectal cancer were treated with laparoscopy-assisted posterior LAR in the Department of General Surgery of Beijing Chaoyang Hospital.”

d. The authors start presenting results in the method – e.g. height data

Are the complication results to 30 days, or beyond? Were all patients actively followed up or was this a notes review?

Author’s response: We thank the reviewer for his/her comments. This manuscript is a prospective article rather than a case review. We have revised the 2nd paragraph of the Results section, as follows:

“…All complications occurred within 30 days, and we did an active follow-up on all patients.”

e. Please can the authors more definitely explain what they mean by ‘posterior approach’, for the non-expert reader. This is important to differentiate whether they are progressing knowledge based on laparoscopic assisted surgery with a Pfannenstiel (which they are, through a laparoscopic TME completed by a
perineal incision [...]. The single sentence explaining it can be expanded upon in the introduction - this is the crux of the paper.

Author’s response: We thank the reviewer for his/her comments. We have revised the last paragraph of the Introduction section, as follows:

…”The term “posterior” (i.e., posterior approach) refers to the approach of posterior perineoplasty.”

3. Discussion

a. APPEAR - “This surgery was easy to perform” – this use of language is inappropriate. I don’t think this is what the APPEAR authors were trying to say.

Author’s response: We thank the reviewer for his/her comments. We have removed the sentence from the 4th paragraph of the Discussion section, as follows:

“The Anterior Perineal Plan E for Ultra-low Anterior Resection of the Rectum (APPEAR) technique,[32,43,44] involved gaining access through the rectum and vagina/prostate plane to the perineal body, then accessing the small pelvic canal, performing joined abdominal operations, and completing the resection and anastomosis. With patients in the lithotomy position, there was no need to turn the patient over to the clasp-knife position, and it was also conducive to retaining anal sphincter function.”

Reviewer’s report #2

Title: Laparoscopy-assisted posterior low anterior resection of rectal cancer

Version: 3 Date: 17 June 2014

Reviewer: Andrew Beggs

Reviewer’s report:

The authors are to be congratulated on a well written paper on Laparoscopic posterior LAR. In particular the figures are excellent and enhance the paper. The paper is suitable for publication, and I have a few minor points to enhance the manuscript:

Minor essential revisions:

1) Page 3 - I would disagree with the authors that the effectiveness of laparoscopic rectal surgery is under question. The MRC CLASSIC trial has shown the oncological outcomes are similar to open - this should be reflected in the manuscript.

Author’s response: We thank the reviewer for his/her comments. We have revised the 3rd paragraph of the Introduction section, as follows:

…”This is especially true if the surgeon does not have sufficient experience in open TME and advanced laparoscopic surgery, although the MRC CLASSIC trial has shown that the oncological outcomes are similar to open.[25]
2) Introduction

I think the authors should emphasize in their introduction that their described technique is for low stage rectal tumours, as T3/T4 tumours would still be dealt with in the normal way.

Author’s response: We thank the reviewer for his/her comments. We have revised the 4th paragraph of the Introduction section, as follows:

“In addition, for middle and low rectal cancer, especially in overweight patients or patients with a narrow pelvis, it is difficult to treat the bowel at the distal end of a tumor. Thus, for middle and low rectal cancer, especially for patients with a lower tumor edge at 2-5 cm from the dentate line, laparoscopy-assisted posterior low anterior resection (LAR) of rectal cancers is performed, although the procedure remains controversial. T3/T4 tumors would still be dealt with in the normal way.”

3) p7 line 148 – “an anal canal was placed from the anus” - this makes no sense and should be revised

Author’s response: We thank the reviewer for his/her comments. We have revised the 8th paragraph of the Methods subsection Surgical procedure, as follows:

“A presacral drainage tube was placed from the perineum and an additional drainage canal was placed in the anus (Figure 6).”

4) p12 line 147 - “but also can handle certain pelvic floor complications which appear when separating bowel under endoscopy, such as pelvic floor bleeding” - it is not clear what the authors mean by this - please revise

Author’s response: We thank the reviewer for his/her comments. We have revised the 5th paragraph of the Discussion section, as follows:

…”but also can handle certain pelvic floor complications which appear when separating bowel under endoscopy, such as bleeding.”