Author's response to reviews

Title: Stent versus gastrojejunostomy for the palliation of gastric outlet obstruction: a systematic review

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Author's response to reviews: see over
Dear Dr. Chrissie,

Thank you for reviewing our manuscript, entitled:

"Stent versus gastrojejunostomy for the palliation of gastric outlet obstruction: a systematic review."

Point by point we will discuss the comments you and your reviewers had:

Reviewer: I. Maetani
Minor essential revisions
1. In the Discussion section, you offer your opinion on covered stents. Although I agree with your opinion, you should refer to the articles regarding the use of covered stent for gastric outlet obstruction such as [Ref#23, 25, 29, 30, 42] in stead of esophageal obstruction [Ref#52].

We agree with the reviewer that we should refer to articles regarding the use of covered stents for gastric outlet obstruction, instead of referring to an article on esophageal obstruction. We therefore corrected the referred references (Discussion, page 13, line 3).

2. P.7 Last line: A misspelled word “Giaturco” should be replaced with “Gianturco”.

The spelling is corrected (Results, page 8, line 4).


The spelling is corrected (Author’s contribution, page 15, line 23).

Discretionary revisions
1. You conclude that stent placement may be associated with more favorable results in patients with a relatively short life expectancy, while GJJ is preferable to patients with a more prolonged prognosis because the results show that recurrent obstructive symptoms were more common after stent placement (18% vs 1%). As time passes, the possibility of the stent occlusion probably increases. I think that stent obstruction probably occurs as a late-onset adverse effect unlike stent migration. To emphasize conclusion, however, it is desirable to display the period until recurrent obstructive symptoms are seen in reference to available data of published studies.

We agree with the author that it would certainly add more insight into the comparison between GJJ and stent placement with regard to recurrent obstructive symptoms. However, these data are only minimally available. Nonetheless, we added a summary of available data to the Discussion (page 13, line 3-5).
Reviewer: A. Repici
Discretionary revisions
1. It could be useful, if possible, to compare the results of patients treated with uncovered versus covered stent. May the use of a covered stent afford a more prolonged benefit on luminal patency? This issue has been already proven for the esophageal cancer and it would be nice if the authors could mention this possibility in the discussion, even as potential improvement for the future. Moreover, it would be interesting to compare the outcomes of the two different approach basing on the cause of duodenal obstruction. Does the obstruction from a pancreatic cancer behaviour differently than an obstruction from a primary duodenal adenocarcinoma? How this can impact the outcome of the two different treatments?

Indeed it would be interesting to compare the results of patients treated with uncovered stents with patients treated with covered stents. Unfortunately, these data are hardly or not available. In many studies, no distinction was made in patients treated with a covered or uncovered stent. The available information was added to the Discussion (page 13, line 3-7).

Reviewer: T. Baron
Discretionary revisions
1. On page 12, paragraph 2, one of the factors which may contribute to the wide variation in complications (as well as success) is operator experience. We agree with the author that operator experience may also contribute to the wide variation in complications. This was added to the Discussion (page 12, line 13-14).

Reviewer: G. Lindberg
Discretionary revisions
1. I am a little surprised by the abbreviation GJJ for gastrojejunostomy. Wouldn’t GJS be more adequate? Not many centers, at least in Europe, have large numbers of patients that would be suitable for a randomized study. I think this is a typical area in which a cooperative multinational study should be initiated. Perhaps the authors could provide some estimates on the expected annual number of adult patients per million inhabitants who would need this kind of treatment per year.

It is known that 15-20% of patients with pancreatic cancer develop gastric outlet obstruction (Background, page 4, line 3). According to Dutch figures, the incidence of pancreatic cancer, the largest group of patients developing gastric outlet obstruction, was 7.1 per 100,000 people in 2003. Based on this, it is expected that worldwide 71,000 people will annually develop pancreatic cancer, of which approximately 11,000 to 14,000 patients (15-20%) will develop gastric outlet obstruction. This information was added to the Background (page 4, line 3-4).

We hope that we have answered the raised issues and comments correctly and hope that the manuscript is acceptable for publication in BMC Gastroenterology.
For any more questions and/or comments, you are more than welcome to contact us.

Sincerely yours,
on behalf of all co-authors,

Suzanne M. Jeurnink                                Peter D. Siersema