Author's response to reviews

Title: Single-incision laparoscopic cholecystectomy for cholecystolithiasis coinciding with cavernous transformation of the portal vein: Report of a case

Authors:

Takuro Shirasu (shirasu-tky@umin.ac.jp)
Yoneei Kawaguchi (ykawaguchi-tky@umin.ac.jp)
Junichiro Tanaka (junjunkonnichiwa@yahoo.co.jp)
Yoshiro Kubota (ykubota@mail.kikkoman.co.jp)

Version: 8 Date: 17 March 2013

Author's response to reviews: see over
Reviewer's report

Title: Single-incision laparoscopic cholecystectomy for cholecystolithiasis coinciding with cavernous transformation of the portal vein: Report of a case

Version: 6 Date: 3 January 2013

Reviewer: Gregory Kouraklis

Reviewer's report:


Re-evaluation:

Dear editors according to our primary review of the above mentioned case report single incision laparoscopic cholecystectomy with co-existance of other intra-abdominal conditions is not described for the first time. However, this is a good written case report and if the authors adopt or comment on the reviewers comments the manuscript could be considered for publication with low priority.
Associate Editor comments:

1. the paper is worth while publishing I agree with the first reviewer and the revised second review opinion; the reasons are: cavernous transformation of the portal vein is rare but can coincide with symptomatic cholecystitis so such case report is of value as surgeons might encounter such anatomical situation and this paper would prepare them should they find such a situation coincidental. It is good and interesting to see that the authors managed to perform the operation successfully although they opted for SILC. Even more astonishing is the fact that they managed to screen the situation beforehand and still went ahead to perform SILC. It demonstrates that this technique can be implemented even if there are anatomical variations. It is later highlighted that there was significant blood loss and a long operating time, this should warn other surgeons not to undertake such procedure in anatomical variations, if they are not experienced in this procedure.

Thank you for supporting our report. We took care of describing the case for other surgeons to follow our experience and difficulty in this case.
2. It is important that papers about experience with new techniques like SILC are published. It should be open for debate whether or not it was the right choice to perform this particular cholecystectomy in this fashion. But it illustrates that complications like the encountered once can be overcome. I personally would have chosen a standard laparoscopic cholecystectomy and converted if bleeding could have not been better controlled quickly.

Bleeding is the concern in this case. We might have minimized bleeding if we kept the cystic duct with neighboring cavernous vessels from the beginning. So the text was revised as follows;

Page 6

We decided to sacrifice these vessels during the surgical procedure.

>> We were determined that these vessels could be sacrificed during the surgical procedure.
Although it took relatively little time to control the bleeding when we kept the cystic duct with neighboring cavernous vessels, this maneuver caused the most bleeding. We spent considerable time removing hematomas.

We think that the main cause of bleeding is that we tried to detach the cystic duct from neighboring cavernous vessels. These vessels were too fragile to be completely preserved in keeping the cystic duct. The small collateral vessels can be safely sacrificed to minimize bleeding.

3. interesting there is no long term follow up, one has not got any information about liver enzymes parameters for example one month after surgery. Should there be a problem with portal vein flow due to the resection of 2 small arms, this would show only at a later stage. In particular it would be important to know whether there was no ascites and no increase of portal vein pressure. One would especially be interested if the patient was asymptomatic 4 weeks after the procedure.

The long term clinical outcome of the patient (liver enzymes, clinical symptoms, ultrasound examination to exclude ascites) 4 weeks after the operation should additional
be included into the revised manuscript.

We also thing this is the important point and the manuscript was rewritten as follows.

The last follow-up day was postoperative day 8, when she was asymptomatic and her blood test revealed her liver enzymes were within normal limits. A longer follow-up would be better, but we cannot get in touch with her with all means.

Page 7

She was uneventfully discharged on postoperative day 2.

>> She was uneventfully discharged on postoperative day 2. The liver enzymes dropped within normal ranges and she was asymptomatic on the last outpatient day of postoperative day 8.