Title: Modified capitonage in partial cystectomy performed for liver hydatid disease. Report of 2 cases.

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To: BMC Surgery
   c/o Editor

Subj.: Revision of the article: Modified capitionage in partial cystectomy performed for liver hydatid disease. Report of 2 cases.

Dear Editor,

Thank you very much for your useful suggestions of your reviewers concerning our submitted manuscript. We tried to revise the paper and answer to the questions. In the present letter I’m trying to answer the reviewers’ comments and questions. You can also find attached the revised paper.

Reviewer 1: Thank you very much for your useful suggestions.

General:
(1) It is mandatory …. PAIR procedure …. More radical operation.

Answer: A short reference to PAIR procedure was omitted by our fault as the reviewer correctly noticed. We consider that PAIR procedure is of great value in the treatment of liver hydatid disease, it is a minimally invasive method with important advantages. We refer PAIR procedure in the revised paper in introduction and in discussion as the reviewer suggested:

(1) Introduction: ….. PAIR which belongs to the minimally invasive techniques, a real alternative to surgical procedures and chemotherapy, is of great value especially in cases where surgery and prolonged medical treatment with benzimidazoles is difficult or too expensive…

(2) Discussion: Although our cases where suitable for PAIR procedure (according to the criteria referred by Pelvez et al, Acta Trop 2000;75:197-202) no one of these two patients treated with PAIR because they refused and asked to be treated surgically.

Discretionary Revisions:
(a) Would be nice to report whether or not patients have any adjuvant or neoadjuvant treatment with albendazole and for how long?

Answer: Our patients treated with albendazole. Albendazole was administrated preoperatively (400mgx2) for a month and postoperatively (400mgx2) for three months.
(b) It very well known that a bilateral sub costal incision, or a renal flap incision or a mercedes incision are the best approach for liver surgery. Can the authors explain why they still use a mid line approach?

**Answer:** We agree with the reviewer. We use mid line incision only in selected cases (where it facilitates the operation) because it is less traumatic. We usually use bilateral sub-costal incision. In these particular cases the cysts could easily be removed with mid line incision, and selected this kind of incision for causing less tissue trauma.

**REVIEWER 2.**

Thank you very much for your useful suggestions

**Major Compulsory revisions and Discretionary Revisions**

1. **What are the advantages of this technique over the known capitonnage and introflexion? Both these techniques can be used without omentum as well.**

   **Answer:** Our technique is a modified combination of capitonnage and introflexion. More precisely is a modification of the technique described by Ariogul O et al (Surg Gynec Obstet 1989;169:356-8). It is well known that these techniques can be used without omentum. We propose a new alternative technique with good results, and easy to perform it. In cases that are complicated with postoperative bile leakage the “rosette-like” modified capitonnage may facilitate the drainage easier than the “snail-like” introflexion.

2. **With two cases experience, isn’t very difficult to say that this technique eliminates most of the major postoperative complications after hydatid liver surgery?**

   **Answer:** We agree with the reviewer. The number of patients is too small to extract safe and creditable results, and we do not attempt to do this. What we suggest is an alternative technique with good results in the cases we treated especially as far as it concerns the postoperative bile leaking.

3. **Major determinant of the postoperative biliary and cavity related complications after hydatid surgery is the content of the cyst, not the cavity management technique. In the text, contents of the cyst where not mentioned. Have you ever seen any biliary orifices in the cyst cavities?**

   **Answer:** We also believe that the cyst content is a major determinant of the postoperative complications. Complicated hydatid cysts present higher complication rates compared to uncomplicated cysts as Kayaalp C et al suggest. (Kayaalp C et al. Arch Surg 2002;137:159-163). In both patients the content of the cyst was bilious and not purulent. Biliary orifices were found in both patients (one in the first and two in the second patient) and treated with sutures.

4. **The limitations and the potential risks of the procedure were not mentioned. For example, is this technique suitable for all hydatid...**
cysts and is there a risk of injury to bile ducts and vessels while passing the sutures from the pericystic wall?

Answer: It’s true that we omitted to refer possible limitations or risks of this technique in the submitted article. We thank the reviewer for this suggestion. In the revised paper we include a paragraph referring to these very important subjects.

In our cases we had no specific difficulties or method related complications. The only possible limitation of this technique may relate with the anatomic location of the hydatid cyst.

Concerning the bile duct and vessel injury, we do not use deep sutures that may cause vessel or bile duct injuries. Our sutures are not deep except from some fixation sutures. We also suggest avoiding deep sutures in locations close to hepatic vessels and inferior vena cava.

(5) Other cavity management techniques are also provide to patients to mobilize on postoperative day one. Therefore, I believe this technique has not any advantage on postoperative mobilization of the patients.

Answer: In many series several techniques present also equal results concerning postoperative patient mobilization. We do not propose that our technique better compared to these techniques, but we propose an alternative surgical technique with very good results and fast postoperative mobilization of the patient.

(6) In the last photograph (with drain), the complete technique looks like introflexion rather than capitonnage.

Answer: Our technique is mainly a combination of modified capitonnage along with introflexion.

(7) Details of the scolicidals are not mentioned. Which concentration? How long?

Answer: Our patients treated with albendazole. Albendazole was administrated preoperatively (400mgx2) for a month and postoperatively (400mgx2) for three months.

Minor essential Revisions

Minor Notes
Hydadid disease should be hydatid
Tude should be tube
Capitonoage should be capitonnage

Answer: The above terms are corrected in the revised text.

Sincerely Yours

Dimitrios K. Filippou, MD, PhD