Reviewer’s report

Title: Paracardial pancreatic pseudocyst with isolated thoracic symptoms: a case report

Version: 3 Date: 20 September 2007

Reviewer: Igor Stipancic

I am familiar with the literature and believe that this case meets one of the 7 criteria for evaluation in the journal: Unexpected or unusual presentations of a disease

Has the case been reported coherently?: No

Is the case report authentic?: Yes

Is this case worth reporting?: Yes

Is the case report persuasive?: Yes

Does the case report have explanatory value?: No

Does the case report have diagnostic value?: Yes

Will the case report make a difference to clinical practice?: No

Comments to authors:

General
Extraabdominal (mediastinal) location of pancreatic pseudocyst is uncommon. Most patients are symptomatic with abdominal pain and unspecific symptoms like chest pain, back pain, dysphagia, odynophagia, weight loss and even cardiac tamponade. Imaging diagnostic tools today (EUS, CT and MRI) can confirm the diagnosis. There are various modalities of treating mediastinal pseudocyst that depend of their size, location, complication, pancreatic ductal anatomy and even etiology. The experience of treating mediastinal pancreatic pseudocyst is limited. Any report and experience in making diagnosis as well as treating modality is worthy.

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Revisions necessary for publication

I think the title "Paracardial pancreatic pseudocyst... ..." is not appropriate. The location is in the mediastinum and term mediastinal should be used. "Mediastinal pancreatic pseudocyst..."
Explanation: Paracardial means chest x-ray description. The pseudocyst is retrocardial actually. For the same reason the term paraesophageal or even prevertebral are not appropriate although they can be used in the same manner as paracardial.

In abstract: (page 2)

Case report: it is important to emphasize that the patient suffered from chronic pancreatitis.

Conclusion: it is not true that in mediastinal pancreatic pseudocysts patient present with acute exacerbation of pancreatitis. (See references 3, 6, 7, 8 10 cited in this article as well as, Mohl W et al Endoscopy 2004;36:467.)

Generally pseudocysts in chronic pancreatitis most often are found in the absence of a recent attack of acute pancreatitis (acute on chronic). It is true that they may develop after an episode of acute attack but more often they appear insidiously.

Introduction – no remarks

Case presentation (page 4). Case reports should include relevant positive and negative findings from history, examination and investigation. It would be wise to note the values of serum and urinary amilase as well as lipase if it was determined.

Description of Fig 3. in text is incorrect. "....(MRCP) showed the cystic stricture with small contact area to the pancreatic tissue and a high-grade stenosis of the pancreatic duct with only moderate dilatation of the proximal duct (Figure3)." this figure shows dilatation of the distal pancreatic duct (part of the duct in the body and tail of the pancreas). It is wise to mention the size of this dilatation especially due to operation that was performed (pancreaticojejunosomy). The size of the pancreatic duct can be measured on transabdominal or endoscopic ultrasound (the later was conducted in this patient as well as ERCP.)

How did "a small intrapancreatic mass at the site of stenosis" suspected? (by endoscopic ultrasound or another diagnostic tool?) I think that this need an explanation.

It will be interesting to see figure of CT scan performed 6 days after surgery. If the authors have that please ask them to present it.

DISCUSSION (page 6)

Authors should be asked to refer on literature correctly. It is incorrect that in reference 6 (Komtong et al JOP 2006;7:405-10.) was description of patient that have acute pancreatic inflammation. In this article (Komtpon et al.) authors deal with posttraumatic pseudocyst without any history of acute attack of pancreatitis.

There is a small typing error in line 12 "dypnea and dyspnea" I suppose that author meant dysphagia.

It is unclear what type of surgery was performed. The authors mentioned external
drainage of the cyst, the resection of the part of the pancreas and side to side pancreateojejunostomy. From surgical point of view it is unclear what type of resection was done and when resection was done why they performed longitudinal pancreateojejunostomy. This part is unclear.

**What next?:** Accept after minor revisions

**Quality of written English:** Needs some language corrections before being published