Reviewer's report

Title: Robot-assisted pancreatoduodenectomy with preservation of vascular supply for autologous islet cell isolation and transplantation: a case report

Version: 1 Date: 27 May 2011

Reviewer: Achilleas Ntinas

Which of the following following best describes what type of case report this is?: Other

If other, please specify:

A challenging and demanding surgical approach to chronic pancreatitis and its sequelae with the use of new technology (robot-assisted).

Has the case been reported coherently?: Yes

Is the case report authentic?: Yes

Is the case report ethical?: Yes

Is there any missing information that you think must be added before publication?: Yes

Is this case worth reporting?: Yes

Is the case report persuasive?: Yes

Does the case report have explanatory value?: Yes

Does the case report have diagnostic value?: No

Will the case report make a difference to clinical practice?: Yes

Is the anonymity of the patient protected?: Yes

Comments to authors:

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First of all, I want to congratulate the authors for their paper. The literature survey to date shows that robot-assisted pancreatoduodenectomy is a very demanding procedure and seems to be rarely performed by surgeons worldwide. Few centers, like that of the authors, have such experience. Nevertheless, I would like the below queries to be answered, for their paper to be fully accepted.
1) It is reported by the authors that CP is from unknown etiology. It is also referred in their paper that the patient had cholecystectomy, choledocolithiasis and was a heavy consumer of alcohol. My opinion is that the etiology is at least alcohol-related. In that case, it is important for the authors to describe better the complete work up of the patient and, with that, to explain their conclusion of the CP’s etiology. Did the authors consider the potential of malignancy and/or autoimmune pancreatitis and how it was ruled out (brush cytology-biopsy)?

2) Many series suggest pain relief with initial stent placement, with or without anatomic resolution of the pancreatic duct stricture. Could the authors comment why this possibility had no place to their patient?

3) It is referred that the sonographic changes were consistent with mild chronic pancreatitis. Based upon which classification? How many abnormal branches of the main pancreatic duct (MPD) existed in their case? What was pancreatic duct’s size of dilatation?

I believe that their criteria of image severity were based on Cambridge classification. I would like to have a comment on that.

4) Given the fact that the size of the MPD in the head of the pancreas is <6.5mm and in the body-tail >5mm (Cambridge classification), I agree with the authors about their choice of operation. However, I would like them also to clarify why they chose a resection procedure (PPPD, Beger, etc) and not a drainage one (Puestow, Partington-Rochelle, Frey etc). It was based on the pattern of anatomy or because the PPPD procedure has a proven track record for pain relief?

5) It is known that we cannot predict the probability of insulin independence after subtotal pancreatectomy. The probability of achieving insulin independence after AIT correlates significantly with the number of islet cell mass that is transplanted, the degree of fibrosis and the dispersion method. I agree that AIT is a safe procedure and the number of islets used was excellent. However, considering the possibility of malignancy, was it necessary? Did the authors evaluate sections of pancreatic tissue for fibrosis? Is the patient still insulin-independent and for how long after the procedure?

Sincerely yours,
Achilleas Ntinas, MD PhD

Quality of written English: Acceptable