Author’s response to reviews

Title: The Role of Endoscopic Ultrasound in Children with Pancreatobiliary and Gastrointestinal Disorders: A Single Center Series and Review of the Literature

Authors:

Alessandro Fugazza (fugazza.ale@gmail.com)
Barbara Bizzarri (bbizzarri@ao.pr.it)
Federica Gaiani (federicagaiani88@gmail.com)
Marco Manfredi (mmanfredi2@ao.pr.it)
Alessia Ghiselli (aghiselli@ao.pr.it)
Pellegrino Crafa (rcrafa@ao.pr.it)
Maria Clotilde Carra (mclotildecarra@gmail.com)
Nicola de'Angelis (nic.deangelis@yahoo.it)
Gian Luigi de'Angelis (gianluigi.deangelis@unipr.it)

Version: 1 Date: 19 Nov 2017

Author’s response to reviews:

Responses to the reviewers’ comments

Reviewers’ comments are identified with R. Authors’ reply with A.

R: Bradley Barth (Reviewer 1): Paper is excellent. There are several articles describing feasibility of EUS in children, but not enough. Particularly interesting to me are the cases involving diagnosis of insulinoma and NET. Also, the lower tract EUS is more novel.

A: Thank you for these encouraging comments and for the time spent to review our manuscript.

R: Amy Tyberg (Reviewer 2): This is an excellent study illustrating the feasibility and safety as well as the importance of performing EUS in pediatric patients.

A few comments:
R1: The authors mention a slim linear scope was used in some cases. How was the decision whether to use a standard vs slim scope determined? Was there a weight cut-off or an age cut-off? In patients in whom the slim scope was required, was there a delay in care due to time required to obtain the scope?

A: Thank you for these encouraging comments and for the time spent to review our manuscript.

The choice of using the scope is based on the age and weight of the patient and considering the sensibility of the imaging obtained with the slim scope (which is less deep, lower quality). Specifically, the linear Slim echoendoscope was used for the upper echoendoscopy in children younger than 10 years and/or weighing less than 35 kg (cases 5, 15, 20 and 32. Table 2), whereas the linear ultrasound bronchoscope was chosen only for the management of case 33, as the child was 4 years old and weighed 13 kg. There was no delay in performing the exams, as all of these echoendoscopes belong to the equipment of the Endoscopy Unit, and they are regularly used especially for pediatric patients. This information has been added in Page 6, lines 3-7.

R2. Is there follow-up on the patients who underwent EUS for suspected choledocholithiasis and were found to not have stone disease requiring ERCP? Did any of these patients ultimately require ERCP?

A: Among patients who underwent EUS for suspected CBDs or biliary pancreatitis, 12 of them (cases 1, 4, 6, 7, 10, 12, 15, 21, 26, 29, 34, 37; Table 2) avoided ERCP and underwent laparoscopic elective cholecystectomy, with a 4-week surgical follow-up. Five (cases 2, 3, 23, 25, 32; Table 2) avoided ERCP, but those presenting with comorbidities affecting biliary ducts (e.g., sclerosing cholangitis, cases 3, 23, 25) were followed up by abdominal ultrasound and/or MRI and biology according to the ACG guidelines (Lindor KD et al, Am J Gastroenterol 2015); the two patients who underwent EUS for pancreatitis in absence of other pancreatobiliary comorbidities were followed up clinically and with biology tests after 6 and 12 months, including complete hepatic function tests, CRP and lipase, documenting a complete normalization of both clinic and biology. Information about follow-up has been added in Page 10, lines 14-22.

R3. One could make the argument to add a 4th criteria in assessing the clinical impact of EUS for the patient who underwent cystgastrostomy - the EUS in that case not only yielded new findings that altered the management, it allowed for therapeutic treatment of the condition.

A: The fourth criterion was added (Page 7, line 16 and Page 12, lines 17-18), as the patient was treated thanks to a EUS-guided placement of a cyst-gastrostome, which treated successfully the pseudocyst.