Title: Risk factors and outcomes of postoperative pancreatic fistula after pancreatico-duodenectomy: an audit of 532 consecutive cases

Authors:

Shunjun Fu (fsj103@163.com)
Shenli Shen (beyondjulian@163.com)
Shaoqiang Li (lisq@medmail.com.cn)
Wenjie Hu (shijie730701@163.com)
Yunpeng Hua (hyp0427@163.com)
Ming Kuang (kuangminda@hotmail.com)
Lijian Liang (lianglijian1946@163.com)
Baogang Peng (pengbaogang1963@163.com)

Version: 2 Date: 2 January 2015

Author's response to reviews: see over
Dear Editors:

We thank you and the two distinguished reviewers for their critical and insightful comments concerning our manuscript entitled “Risk factors and outcomes of postoperative pancreatic fistula after pancreatico-duodenectomy: an audit of 532 consecutive cases” (MS: 3184815114652849). Those comments are valuable and helpful for revising and improving our manuscript. We have studied the comments carefully and have made correction which we hope meet with approval. The responses to the reviewer’s comments are as listed as follows.

Reviewer: 1

1. Abstract

Discretionary revision

As far as the risk factors are analyzed before the outcomes, it would be logical to change risk factors and outcomes in the Conclusion part of the abstract

Response: We have revised the order, as follow “Blood loss ≥ 500ml, pancreatic duct diameter ≤ 3mm and pancreatico-jejunostomy type were independent risk factors of PF after PD. PF was related with higher mortality rate, longer hospital stay, and other complications.”

2. Introduction

Response: We added “Some risk factors for PF after PD have been
described in the literature and included the following: patient demographics, diameter of pancreatic duct, pancreatic texture and anastomotic technique [5-8]” in paper. And deleted references 1 and 2.

3. Material and Methods

1) detail regarding biliary drainage might be excessive, as there is no further analysis according to the subtypes of drainage. Perhaps, the percentage of patients with biliary would suffice.

Response: We have revised in paper according to your suggestion.

2) 90-day post-operative mortality might be used as far as a good deal of patients with PF can live longer than 30 days in ICU an still succumb to the disease.

Response: “The operative mortality was defined as death within 30 days after operation or before discharge from the hospital (irrespective of the duration of stay)” . Although a good deal of patients with PF can live longer than 30 days in ICU, they didn’t discharge from the hospital.

3) major compulsory revision:

The authors use a universally used definition of PF. However, the same International Study Group on Pancreatic Surgery (ISGPS) suggested similar definitions for delayed gastric emptying (DGE) and post-pancreatectomy hemorrhage (PPH). Also, the authors refer to the Clavien-Dindo classification of complications, but do not use it. Those are universally accepted classifications which are most
necessary to be used so that the presented results could be compared to other series.

Response: We have fully accepted your advice and revised in paper.

4. Results

1) data regarding the number of PF in patients with rare indications for Whipple (like 3 out of 6 etc.) can not show the rate of PF due to the small number of events. Perhaps, table 1 could be made much shorter or skipped.

Response: We have skipped related content and table 1 according to your advice.

2) the section on post-operative outcomes could be more precise. Dindo-Clavien classification of complications should be used which also affords to compare mild vs severe complications.

Response: We have added related content in paper.

5. Discussion

1) Most of the studies showed that soft pancreatic tissue and narrow pancreatic duct are the most potent contributors to PF formation. Those studies shall be discussed in more detail, especially as in the present study the “softness” of the gland didn’t appear to influence the outcome.

Response: We have added related content in paper.

2) The study of Bartoli et al. ([28]) is very old and hardly relevant
today. However, lots of corresponding studies were published in the recent 5 years, that might be overviewed in the discussion.

Response: We have deleted reference 28.

3) Conclusion regarding advantages of the duct-to-mucosa anastomosis cannot be driven by the present data. The authors claim that in their experience this anastomosis had better results, however, the choice of the anastomosis type was random. Naturally, surgeons tend to use d-to-m. anastomosis in patients with a wild duct and other types in narrow duct cases, which will inevitably lead to poorer results among other types. Such a question (and a conclusion) might be addressed in a randomized trial which is not the case. Perhaps, the moment might be skipped without losing of the papers’ quality.

Response: We completely agreed with your view and deleted related content.

Reviewer 2

Major Compulsory Revisions

1) Delayed gastric emptying and postoperative bleeding should be classified according ISGPS recommendations

Response: We fully accepted your advice and revised in paper.
2) International classification of the postoperative complication should be applied

Response: We have applied international classification of the postoperative complication in paper.

3) The single center non-randomized trial provides too small evidence to recommend a type of pancreaticojejunostomy in compare to existing trials. The type of pancreatojejunostomy should be recommended in conclusion, based on these results.

Response: We have accepted your suggestion and deleted related content.

Minor Essential Revisions

Too much has been published on the same topic, showing same and other risk factors. That should be better clarified in discussion.

It is also necessary to show how the obtained results should influence surgical tactics: implementation of the techniques that decrease intraoperative bleeding, such as IPDA first approach, e.t.c.

Response: We have accepted your suggestion and added related content.