Author’s response to reviews

Title: Early Outcome of Frey’s Procedure for Chronic Pancreatitis: Nepalese Tertiary Center Experience

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Cover letter about revision BSUR-D-19-00364
Thank you so much editorial office and the all the reviewers for their comments and genuine feedback. We have tried to revise the manuscript accordingly and replied those issues as much as possible from our side. Hope we would be able to convince in regards.

Thank you so much

Response to
Ulrich Friedrich Wellner, PD Dr. med. (Reviewer 1):

The authors present a study of 26 Frey procedures for chronic pancreatitis performed in Nepal. The study is well written using adequate methodology, but is purely descriptive without novel aspects on this topic.

-Reply –
Thank you so much for the review. Well this is a mainly descriptive study. We want to emphasize the importance of surgical management of CP in form of Frey’s procedure in achieving effective pain control along with preservation of exocrine and endocrine function with acceptable perioperative complications. The most important thing is able to get approximately comparable results in limited resource setting. As most patients belong to rural areas, frequent hospital visit is great financial as well as physical burden, so able to provide efficacious long term treatment is the goal and we want to share our experience from resource limited developing countries.

On the other hand, half of the cases were performed for tropical pancreatitis and there is rarely any literature on Frey procedure for this special disease. So I would suggest to change the aim to analyze this issue, and compare tropical to other pancreatitis, in baseline as well as surgical aspects. A review of the current literature could also be amended.

-Reply –

The effectiveness of Frey’s for tropical pancreatitis from India had been reported in discussion. We also analyze the cases in regards of tropical versus non-tropical and formulated separate table.

Mathias Worni, PD Dr. med. (Reviewer 2): Review Digestive Surgery: BSUR-D-19-00364

I appreciate the opportunity to review this article. I congratulate the authors of putting their data together to show the medical community the Nepalese experience in surgically treating patients with chronic pancreatitis. However, the manuscript needs extensive language polishing. Some additional points below:

Major points:
- Median f/u of only 17 months does not really allow to talk about long-term outcomes - I would motivate the researchers to f/u those patients further to get a real long-term f/u after a median of 5 years

Yes definitely long term assessment really need at least 3 or 5 years of follow up. But we are trying to assess both short- and long- term outcome as much as possible regarding our surgical treatment. Getting the achievable perioperative outcome along with durable response will be our goal. Hopefully we will be able to get persistent and durable pain relief even on 5 year follow up.
This is one main limitation of the study.

- Results: please omit description of tropical pancreatitis in the results section - this is discussion or maybe consider adding a couple of sentences to the intro.

Yes this line is added into introduction. Yes as per the feedback by another reviewer, some more insight regarding tropical pancreatitis is added in discussion.

- Please describe how many patients underwent which other kind of operation (PD, Beger,…) and why they were not considered to be suitable for a Frey procedure.

Besides Frey’s, PD were performed in 7 cases of obstructive jaundice with suspected periampullary cancer & carcinoma head pancreas. Similarly one case of CP with biliary stricture had underwent Beger with Bern modification while remaining 4 cases underwent Partington- Rochelle procedure. Our current institutional practice regrading surgical management, PD or DP in suspected mass lesion likely
of malignancy, Partington-Rochelle procedure if only dilated duct without bulky head and Frey if both dilated duct and bulky head. Choice of Frey’s is made on basis of imaging and intraoperative finding of bulky head >4cm along with MPD of >7 mm.

- Results: the presentation of the results for the postop pain score is insufficient - it remains unclear when it was measured (e.g. mean postop VAS score) - were there multiple scores taken for each patient - could you draw a curve to show the development of the pain score over time? At one point you say that f/u was inconsistent for timing but here you say Izbicki score was performed "exactly" after 3 months - how was this assessed?

Pain score is evaluated using VAS and Izbicki score. Patients pain score and any other issues were evaluated on every possible hospital visit and especially at 3 month and 12 months postoperatively. If patients couldn’t visit hospital, they were telephoned after 3 month, 12 month and last assessment at time of analyzing all patients for this study. Also, the postop VAS score calculated is maximum VAS pain score over follow up time.

- discussion: please start the first paragraph by a short summary of the main findings not with the differences in etiology of pancreatitis

revised accordingly

- the authors are presenting Nepalese experience - it would be good to get more insight into the situation in Nepal and they should be put into perspective of other countries to increase generalizability.

Yes the prospectives from other countries like India and Japan had been reported in discussion. And the important point is to achieve approximately comparable outcome in resource limited setting like ours.

Minor points:
- Introduction: last sentence - please add what gastroenterologists advocate for and why they try to delay surgery to complete the thought

Gastroenterologists usually try to opt endoscopic treatment before considering surgical treatment as it is less invasive and without major complications. But the success of endoscopic stenting and complete pain relief depends on the expertise. Consideration of repeated hospital visits and all expenses along with risk of opioid dependence is major issue.

- methods: do you choose patients after interdisciplinary discussions between gastroenterologists and surgeons? How many endoscopies are tolerated before surgical treatment is discussed? What was the treatment of endoscopists if only one patient underwent an ERCP with stenting?

Well cases of CP are seen by both GI surgeons and Gastroenterologists. Pain is initially managed with analgesics by both but further treatment depends on availability and patient compliance. As majority of patients belong to rural areas, surgery is favorable choice as endoscopic treatment might be repeated and overall more costly as compared to usual single time durable and affordable treatment in form of surgery. Usually gastroenterologists are the one who do endoscopy and stenting and is in developing period. Definitely many patients from capital are under endoscopic treatment under gastroenterologist and hence they are not considered in our series. So the data presented are just the cases managed surgically till now. So considering all these things, treatment before development of complications and for achieving durable outcome, surgery can be advocated in our patients before development of steroid
dependence.

- methods: why was stool elastase not checked to assess exocrine pancreatic function - did this change after surgery or were the two with insufficiency before the same as afterwards?

Stool elastase is not available in our setup and is cumbersome to send large stool sample to India for investigation, so the assessment of exocrine pancreatic function (steatorrhea) is based on clinical judgement only. No new cases developed steatorrhea in postoperative period.

- results: how was pseudocyst drainage being performed - by surgery, endoscopy or ct/ultrasound guided?

Pseudocyst drainage were performed in 2 cases via USG guided percutaneous drainage.

- one patient died with likely liver cirrhosis - how do you handle such patients and when do you still perform surgery given high risks for complications

That casualty is obviously a dreaded spectrum of surgical management. The case was alcoholic CP discharged well on 6th postoperative day but developed UGI bleeding requiring ICU management and transfusion. But unfortunately he belong to remote area and before presenting to our hospital or other tertiary center, it was lost in nearby local hospital. Had it be transferred to our hospital, possibly immediate mortality could have been avoided. Preoperative status was controlled, well compensated cirrhosis without previous history of UGI bleeding (Varices), so in owing to intractable pain, decision of surgery was proceed but we lost him.

- values need units (eg. amylase in the drain)

Amylase value – Unit/Liter (U/L) and normal value is up to 80 U/L