Reviewer's report

Title: Surgical treatment of gastric venous congestion in association with extended resection of pancreas

Version: 0 Date: 20 Nov 2019

Reviewer: Reviewer 2

Reviewer's report:

PEER REVIEWER ASSESSMENTS:

RELEVANCE - Does this case report make a contribution to medical knowledge, have educational value, or highlight the need for a change in clinical practice or diagnostic/prognostic approaches?

Yes, this report contributes to medical knowledge

CASE DESCRIPTION - Are the details of the case sufficiently well described to understand the patient's symptoms and course of treatment?

No - there are minor issues

DIAGNOSIS/INTERPRETATION - Based on the facts presented, are the diagnosis, interpretation, and course of treatment medically sound?

Yes, the work described is medically sound

DISCUSSION OF THE CASE - Does the discussion appropriately analyse the importance of the findings and their relevance to future understanding of disease processes, diagnosis or treatment? Has an adequate literature review pertinent to the case been included?

No - there are minor issues

OVERALL MANUSCRIPT POTENTIAL - Could an appropriately REVISED version of this work represent a technically sound contribution?
Probably - with minor revisions

PEER REVIEWER COMMENTS:

GENERAL COMMENTS: What is your overall impression of the report?

This is a very unusual case, most other cases of left sided portal hypertension occur after a proximal pancreatectomy when the SpV, portal vein, and SMV confluens must be resected with the SpV fully lighted.

In this case the tumor, its effects, or a poorly planned ligation of the SpV led to obstruction of the LGV and isolation of the gastric venous drainage of the stomach. The situation involves the majority of the stomach being drained only by the LGV which should be considered as possible and looked for after a total pancreatectomy.

Overall I really like this topic and it has a message. Many of the pancreatic resections for pancreatic cancer involving the extrahepatic portal venous system (which includes the veins draining the stomach) require cognizance of the adequacy of the gastric venous outflow. This paper offers a chance to also address the potential problems with a proximal pancreatectomy which would markedly strengthen the paper.

Points that would increase the impact and educational value and be a bit more transparent about the cause of the venous stenosis of this already interesting and worthy case report:

1. Address why a venoplasty as opposed to a full end to end anastomosis was not possible - was it entertained?

2. Describe whether the "stenosis" of the LGV was present before the SpV was ligated or whether the "stenosis" occurred after locating the SpV - was there a technical local error in where the SpV was ligated?

3. Downplay the importance of the RGV which is almost never an important gastric vein.

4. Introduce a short one or two sentence phrase acknowledging that sinistral hypertension and worries about gastric venous hypertension and it's potentially very important consequences (bleeding from Gastric varices and rarely gastric necrosis) and provide 2 relevant and educational previous publications.

In summary I am very supportive of this publication which will be important to pancreatic surgeons. Also the authors should be applauds for recognizing the gastric venous outlet obstruct and team eating it intraoperatively.
* Are you confident in the authors' description and interpretation of the report?

Yes but there is one question about the claim of LGV "stenosis". Did the tumor cause fibrosis or did the tumor effectively obstruct this entry of the LGV into the SpV or was it a technical misadventure; this point is obscure and needs to be clarified. Apparently, there was no obvious obstruction preop or at the time of the operation, suggesting that the ligation of the SpV was a technical error.

* Have the authors clearly outlined the need for publication by novelty of the case or the specific adverse event?

Although this is an unusual situation, their explanation and operative recovery to accomplish a decompression of gastric venous obstruction is so much easier than the other solutions. Yes I think that there is less well understood concern for left sided venous obstruction after certain types of pancreatectomy with splenectomy.

REQUESTED REVISIONS:

Suggested changes

1. In the abstract you should delete all the abbreviations of Splenic vein and left gastric vein,

2. Page 3 line 50 define the cell of origin of the pancreatic cancer. e.g. ductal adenocarcinoma

3. I think you should explain why there was no bleeding when a distal gastrectomy is performed comcomitantly this would seem to the casual reader to be just the opposite.

4. Page 4 line 66 reword to "invaded the SpV just distal to the entry of the LGV into the SpV" I would not use the term "confluence" it really is "confluentes". Ion line 69 would say the "stenosis is the entry of the LGV into the SpV"

5. Figure 1 ease orient the reader to where the head and feet and right and left are in the figure.

6. Combine figure 1 and 2. I would delete figures 3 and 4 these are unnecessary, all surgeons will know this.
7. Lines 81 -89 I would avoid saying that this was sinistral hypertension which usually occurs from obstruction of the SpV leading to splenomegaly and gastric varicies. You can refer to it as a form of sinistral hypertension after a splenectomy That will be less confusing in this patient because she had a splenectomy. Also of indeed there was a technical problem of locating the SpV too close to the entry of the LGV the best to call the stenosis "iatrogenic"

8. Page lines 103-107 shouldn't you also warn the reader to look for evidence of increased gastric and perigastric venous system at the time of a total pancreatectomy with splenectomy?

9. Figure 1 could you put an arrow on the tumor near the entry of the LGV into the SpV?

10. Shouldn't you also discuss briefly the development of left sided portal hypertension after a proximal pancreatic resection when the gastrosplenic venous drainage is obstructed and some form of a portal decompression is required. This actually is a much more common problem. There is a great paper on this by Kathleen Christiansin SURGERY 165; 298-306, 2019. This is more common than gastric venous drainage problems after a total pancreatectomy. This paper discusses several types of decompression. At that time there is another paper from a Japanese group Tanaka et al SURGERY 165; 291-297, 2019 That talks about preservation of the gastric veins during a pancreatectomy —it would add educational value to the case report. I would also stress that maintenance of gastric venous outflow as requiring one of the important gastric veins along either the greater or lesser curvature.LGV, right gastroepiploic vein( provides there is venous continuity with the left gastroepiploic vein and ongoing presence of the spleen. I really doubt that the right gastric vein is important in this regard.

11. Why didn't you do a venoplasty rather than an end to end anastomosis.

12. finally congratulations for both recognizing the gastric venous outlet obstruction AND fixing it Intraoperatively!- WELL DONE!

ADDITIONAL REQUESTS/SUGGESTIONS:

see above

Are the methods appropriate and well described?
If not, please specify what is required in your comments to the authors.

No

Does the work include the necessary controls?
If not, please specify which controls are required in your comments to the authors.

Yes
Are the conclusions drawn adequately supported by the data shown?
If not, please explain in your comments to the authors.

Yes

Are you able to assess any statistics in the manuscript or would you recommend an additional statistical review?
If an additional statistical review is recommended, please specify what aspects require further assessment in your comments to the editors.

Not relevant to this manuscript

Quality of written English
Please indicate the quality of language in the manuscript:

Acceptable

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