

**Review Form 1.7**

Journal Name:	<b>Asian Journal of Research in Surgery</b>
Manuscript Number:	<b>Ms_AJRS_109538</b>
Title of the Manuscript:	<b>Shaheed procedure: An Innovative Technique in the Management of Chronic Pancreatitis Calculous.</b>
Type of the Article	<b>Original Research Article</b>

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**PART 1: Review Comments**

	<b>Reviewer's comment</b>	<b>Author's comment</b> (if agreed with reviewer, correct the manuscript and highlight that part in the manuscript. It is mandatory that authors should write his/her feedback here)
<p><b>Compulsory REVISION comments</b></p> <ol style="list-style-type: none"> <li>1. <b>Is the manuscript important for scientific community?</b> (Please write few sentences on this manuscript)</li> <li>2. <b>Is the title of the article suitable?</b> (If not please suggest an alternative title)</li> <li>3. <b>Is the abstract of the article comprehensive?</b></li> <li>4. <b>Are subsections and structure of the manuscript appropriate?</b></li> <li>5. <b>Do you think the manuscript is scientifically correct?</b></li> <li>6. <b>Are the references sufficient and recent? If you have suggestion of additional references, please mention in the review form.</b></li> </ol> <p><b><u>(Apart from above mentioned 6 points, reviewers are free to provide additional suggestions/comments)</u></b></p>	<p><b>Introduction:</b> It is written inappropriately. He has not given deficiencies of the present ongoing procedure and the need of Shaheed procedure and its advantage is only one anastomosis. The Roux and Y with two anastomoses. He has not given the rationale of two anastomosis. In chronic calculous pancreatitis, pain is the predominant symptom. Over time, it becomes intractable. It hampers patients' daily activities, causing them to become unresponsive to drug treatment. The aetiology of pain is multifactorial. Pain in pancreatitis is due to perineural inflammation;<sup>1,2,3</sup> ductal hypertension caused by stones or stricture is the primary cause of pain in chronic pancreatitis.<sup>4-9</sup> Among the different modality treatments, surgical treatment is the last option. Surgical options are resection, decompression and a combination of resection and decompression. Many authors have introduced several procedures. Depending on the benefit of surgery, the surgeon chooses the best option. Extended drainage operations such as Beger<sup>5</sup> and Frey<sup>6</sup> were quickly adopted in Europe and have proven equally effective in morbidity, mortality, and pain relief. Proponents of drainage procedures such as lateral pancreatojejunostomy (LPJ), modified Puestow or Partington procedure sufficiently decompress the affected ductal system. A resection procedure like pancreaticoduodenectomy that removes the affected head of the pancreas with affected neural tissue is mandatory because the head is the pacemaker in chronic pancreatitis. Stone removal decreases pain; additionally, restitution of pancreatic duct flow improves the physiological function of the pancreas.<sup>10-12</sup></p> <p>Most of the proteins gets absorbed at the proximal 25 CMS of jejunum after mixing with the pancreatic juice at the 2<sup>nd</sup> part of duodenum. If the pancreatic juice is delivered 50 CMS distal to the DJ flexor, the protein digestions, the bowel flora is likely to get disturbed. The author has not mentioned the distance from the DJ flexor where the first anastomotic suture for pancreatoco jejunostmy is done.</p> <p>If the author is averse for the second anastomosis, single pancreatoco- gastrostomy shall be more appropriate. Acidic gastric pH will not activate the pancreatic enzyme and it will only get active in duodenum with alkaline pH.</p> <p><b>Materials and Methods-</b></p> <p>Usually, the identity of the author and the work place kept hidden in the article for review so as to go unbiased. By disclosing the unbiased become reversed.</p> <p>All the cases were diagnosed as chronic calculous pancreatitis with a dilated central pancreatic duct. The duct diameter is 6mm and above. The most common investigation was ultrasonography (Figure 2) in all cases. CT scan, ERCP (Figure 3) and MRCP are also used in some cases. Non-complicated cases like a pseudo-pancreatic cyst, CBD stricture and stone were included in this study. Malignant cases are not included. Viral screening like B and C viruses completed all the cases for patient and surgical team safety. Cancer markers were done as a routine study. They had pancreatic calcification on the plain abdominal radiograph. Depending on the calculi position, they are graded (Table 1) into I, II, and III. Gr. I-stone in the head, Gr. II-stone at head and body, Gr. III-stone throughout the pancreas (Figure 1).</p> <p>The diagnosis is based on USG, CT scan, ERCP and MRI. The author has not mention, why all the tests were needed, as it involves cost radiation besides patient's inconveniences. The author has not considered the functional aspect like diabetes and Steatorrhoea in to consideration as there is no point doing surgery with little function in progressive dysfunction leading to end stage pancreatic failure.</p> <p>Author has designed the pain score and loss of work duration is appositve part of the study, but it seems it was done half heartedly as it was included as indication of surgery.</p>	

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	<p><b>Description of the technique:</b> Anastomosis</p> <p>Mostly the anastomosis anterior mid-point of the duct as the pancreatic tissue is of minimum thickness. So, the loss of available functioning tissue is minimal. However no serious controversy of the authors location of anastomosis. Cutting with knife is bloody and some energy sources minimizes the blood loss. Complete stones removal is appreciated.</p> <p>Has the author assessed the residual stones after surgery?</p> <p>The diameter of the metallic dilator is not mentioned and why the duct needed dilatation when it is &gt;6 mm.</p> <p>The pancreatoco jejunostomy was done at 5-6 cm away from the DJ flexure, is well done. How the leakproof tests were done after the anastomosis was needs detailed elaboration and at what pressure the endpoint of leakproof is considered final. Author need to justify why gastric decompression was needed with such beautiful water tight anastomosis?</p> <p>Table-3 each one is 100% makes the table un-necessary; the stone detection rates were different on USG and ERCP are different. The reasons are not elaborated. In a publication mentioning few are diabetes are never written. The exert figure with percentage and medication either oral and insulin dose for control to be added.</p> <p><b>Results:-</b>The follow up period is one month to six years. The author is advised to the calculation on any of the parameter like mean, median with standard deviation. The imaged of USG and X-ray and MRCP are of poor quality.</p> <p>Discussion-</p> <p>The author seep stressing on single anastomosis. He has not given a single image of the surgery even at any stage of surgery. All the points on advantages can be countered</p> <ul style="list-style-type: none"><li>A. Single anastomosis – <b>Author keeps on giving stress</b></li><li>B. Shorter operating time – <b>Not a relevant point in a major surgery</b></li><li>C. Bleeding is very minimal. <b>Author has not defined what is minimal and cutting with knife/ scissors at a highly vascular organ is not tenable.</b></li><li>D. Morbidity and mortality are zero. <b>This point is already addressed</b></li><li>E. No internal herniation. <b>Not a point at all.</b></li><li>F. No attack of pancreatitis. <b>Which attack the author is talking about? Acute pancreatitis?</b></li><li>G. Pain recurrence is 3-4%. <b>This is a good point.</b></li><li>H. Exocrine and endocrine functions preserved. <b>How can he preserved ina progressive disease which progress to end stage pancreatic failure with time.</b></li><li>I. Splenectomy and removal of the tail of the pancreas are not done. <b>It is never done in Chronic pancreatitis unless there is a tumour.</b></li><li>J. No need to mobilize the pancreatic posterior surface. <b>It is never done.</b></li></ul>	
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<b>Minor</b> REVISION comments		
1. Is language/English quality of the article suitable for scholarly communications?		
<b>Optional/General</b> comments		

**PART 2:**

	<b>Reviewer's comment</b>	<b>Author's comment</b> (if agreed with reviewer, correct the manuscript and highlight that part in the manuscript. It is mandatory that authors should write his/her feedback here)
Are there ethical issues in this manuscript?	<i>(If yes, Kindly please write down the ethical issues here in details)</i>	

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