

Peer Review File

Article information: <https://dx.doi.org/10.21037/gc-21-670>

Reviewer A	
Comment 1	<p>Was a pre-operative Ca 19-9 level obtained pre-operatively? Some clinicians now consider pre-operatively elevated Ca 19-9 levels as an indication for neoadjuvant therapy. Please refer to this reference:</p> <p>Bergquist JR, Puig CA, Shubert CR, Groeschl RT, Habermann EB, Kendrick ML, Nagorney DM, Smoot RL, Farnell MB, Truty MJ. Carbohydrate Antigen 19-9 Elevation in Anatomically Resectable, Early Stage Pancreatic Cancer Is Independently Associated with Decreased Overall Survival and an Indication for Neoadjuvant Therapy: A National Cancer Database Study. <i>J Am Coll Surg.</i> 2016 Jul;223(1):52-65. doi: 10.1016/j.jamcollsurg.2016.02.009. Epub 2016 Feb 23. PMID: 27049786.</p> <p>It is possible that this study could have prevented the non-curative surgery and enabled chemotherapy to be initiated sooner, theoretically, avoiding this presentation altogether, or at least, delaying it.</p>
Response 1	<p>We appreciate reviewer highlighting this question. At time of diagnosis, the Ca 19-9 was 394 units/milliliter. Majority of pancreatic adenocarcinoma are associated with elevated levels of Ca 19-9.</p> <p>The time from diagnosis to surgery was 20 days during which, the patient has the necessary preoperative staging work-up, and preoperative clearance.</p> <p>We agree with the reviewer that preoperative neoadjuvant therapy may play a role in patients with elevated Ca 19-9. However, The NCC guidelines version 2.2021 for pancreatic adenocarcinoma treatment as well as American Society of Clinical Oncology Clinical Practice Guideline Update stated that the standard treatment for resectable pancreatic adenocarcinoma currently remains upfront surgery followed by adjuvant chemotherapy. Although the study by Bergquist et al. suggested that neoadjuvant therapy followed by surgery may improve survival, there is no clinical trials that support these findings, and the guidelines are yet to adopt these recommendations.</p>
Changes in the text	<p>The lap results were reported on page 3, line 61-62. A paragraph has been added to the manuscript; Page 6, line 128-135.</p>
Comment 2	<p>Many centers around the world are now doing minimally invasive Whipple Procedures. It seems like a laparoscopic</p>

	<p>approach could have prevented the need to do a laparotomy in this patient. Was the bypass done laparoscopically? What is the therapeutic role of laparoscopy in patients with pancreatic cancer? Theoretically, if this patient was explored laparoscopically, and the bypass done minimally invasively, chemotherapy could have been started sooner and perhaps the presentation of a pericardial effusion mitigated.</p> <p>Gumbs AA, Chouillard E, Abu Hilal M, Croner R, Gayet B, Gagner M. The experience of the minimally invasive (MI) fellowship-trained (FT) hepatic-pancreatic and biliary (HPB) surgeon: could the outcome of MI pancreatoduodenectomy for peri-ampullary tumors be better than open? Surg Endosc. 2021 Sep;35(9):5256-5267. doi: 10.1007/s00464-020-08118-x. Epub 2020 Nov 4. PMID: 33146810.</p> <p>Croome KP, Farnell MB, Que FG, Reid-Lombardo KM, Truty MJ, Nagorney DM, Kendrick ML. Total laparoscopic pancreaticoduodenectomy for pancreatic ductal adenocarcinoma: oncologic advantages over open approaches? Ann Surg. 2014 Oct;260(4):633-8; discussion 638-40. doi: 10.1097/SLA.0000000000000937. PMID: 25203880.</p>
Response 2	<p>We appreciate the reviewer comment highlighting these two land mark papers. The NCC guidelines version 2.2021 for pancreatic adenocarcinoma treatment adopted two surgical approaches including laparotomy or minimally invasive surgery.</p> <p>The surgery initially started with laparoscopic approach to exclude carcinomatosis, then converted to laparotomy to assess resectability. When deemed unresectable, we did the gastric bypass to avoid gastric outlet obstruction.</p> <p>The patient recovery was un-eventful. We referred treatment to oncologist. However, patient developed the cancerous pericardial effusion only 2 weeks following the surgery. We don't believe that having minimally invasive approach could have altered the patient outcomes in this case.</p> <p>High volume tertiary centers may have the privilege to perform minimally invasive Whipple procedure with the reported advantage of shorter hospital stay, minimal blood loss, and lower risk of readmission. However, transferring this patient to high volume center will like postpone definitive care, which will likely impact the patient outcomes.</p>
Changes in the text	A paragraph has been added to the manuscript; Page 6, and 7. Line 136-143
Reviewer B	
Comment 1	<p>The authors report the rare tumor expansion that causes cardiac tamponade in T1 pancreatic adenocarcinoma. The report is very interesting and important for oncologists. However, if possible, I want more information for the cancer</p>

	such as the FDG-PET findings or the findings of arterial or portal phase of dynamic CT of the primary tumor. The value of CA19-9 is also recommended to present.
Response 1	We truly appreciate the reviewer input and recommendations. We edited the manuscript as recommended. Triphasic abdominal CT noted mild peripancreatic edema, with hypo-enhancing abnormal pancreatic head lesion and small peripancreatic lymph nodes, with no enhancing liver lesion, no biliary dilation. EUS did not show suspicious lymph nodes and the biopsy of the primary pancreatic lesion demonstrated Adenocarcinoma. At time of diagnosis, the Ca 19-9 was 394 units/mL, Alpha-fetoprotein was 3.4 ng/mL.
Changes in the text	Details added at page 3, line 60-64. Page 6,7, Line 139-146