Appendix 1: How to use “endnote” in Microsoft Word® 2003-2007

1. Use PUBMED to identify reference(s) to copy and paste into the reference list.
2. To insert a new reference. Click insert: choose reference - footnote - endnote - change number format to 1, 2, 3 (THE NUMBER FORMAT ONLY NEEDS TO BE DONE THE FIRST TIME, then it is automatic the next time).
   Note: In the Word 2007® edition there is a separate heading for references, which directs you to insert endnote. Also, Microsoft for Mac has slight difference.
3. Paste the reference where it appears at the corresponding number at the end of the document.

While pancreatic stents are useful for treatment of pancreatic diseases, inward (proximal) migration remains a problem.¹

References

¹

3. While pancreatic stents are useful for treatment of pancreatic diseases, inward (proximal) migration remains a problem.¹

References

4. To use the same reference subsequently (cross reference)-Click insert: choose reference-cross reference. Under left column, “reference type”, drop down to Endnote. Under the right column where it says “Endnote number” drop down to “Endnote number (formatted)”. THIS LAST PART ONLY NEEDS TO BE DONE THE FIRST TIME, then it is automatic the next time). Note: In Word 2003, cross reference is also found here and directly opens up a list of references to select from or in the insert tab as word 1997.

5. Before closing document or any time a cross reference is inserted-go to “file”-“print preview”. This updates the references (automatically corrects the numbering).

6. The references don’t always appear on the screen but they are present-they will appear when the document is printed or can be seen under “view” at the top left then select “print layout” or “view” and select “footnotes”. Ths is less troublesome with word 2007.

7. Inserting multiple references requires placing put commas between the numbers or it will appear as 1,2,3,4 instead of 1234. Unfortunately this program does not allow references to appear as 1-4. The publisher will manage this. In some cases one may need to superscript the references or to apply brackets, as requested in the instructions for authors.

8. To delete a reference, delete from the text, not in the reference list. This is important-or you will get the error below (#10).

9. If the reference number is copied at the level of the text it can be pasted into another document text section and the reference will appear in the endnotes of the other manuscript (except if it is a cross reference).

10. If “error, bookmark not defined” appears in the text where a reference should be it is either because the primary reference was deleted or it was moved in the text below the cross reference.

Appendix 2: SAMPLE LETTER OF RESPONSE TO MAJOR REVISION

October 24, 2011

John G. Smith, M.D., Editor
Jack. Jones, M.D., Associate Editor
Academic University
5500 Doe Avenue
Somewhere, MN 55372

Dear Drs. Smith and Jones:

Enclosed is the revision of Manuscript Number OA 123456, “management of endoscopic jejunostomy feeding: a retrospective analysis”. We have revised the manuscript in response to the reviewers’ comments as follows:

Reviewer A

Comment 1

a. “The conclusion that D-PEJ is superior to PEG-J needs to be put into perspective. The comparison is not appropriate as a 20-French tube is compared to a 9-French J-tube.”

We agree that the comparison of the two techniques need to be put into perspective, since we are comparing two different caliber size tubes. This is now emphasized more in the discussion section (page 10, 3rd paragraph). We do feel however that it is an appropriate comparison since at our institution the PEG-J using a 9 french jejunal extension is the standard method of endoscopic jejunal placement. We are in the process of prospectively comparing the newer method of D-PEJ placement to the standard PEG-J method at our institution.

b. “Since there was a higher rate of proximal migration of the PEG-J, was the position of the J-tube (beyond the ligament of Treitz) confirmed by fluoroscopy (after withdrawal of the endoscope)?”

All PEG-J tube placements were confirmed to be beyond the ligament of Treitz by fluoroscopy. Comments regarding this have been added to the methods section (page 7, paragraph 1).

c. “The authors need to comment on their previous study (Journal X 20010:65;11-115) where large bore jejunostomy tubes were placed with the help of an ultra thin endoscope. Ten-French to 12-French tubes were used.”

We have now included our previous study of transgastric jejunal tube placement (Journal X 20010:65;11-115) in the discussion section (beginning on page 11, paragraph 1, line 1). This method allows for larger J tubes to be placed endoscopically through existing mature gastrostomy tracts and is a relative easy and safe method, especially for centers that lack experience in D-PEJ placement. However, we feel that it is not valid to compare this population of patients to the patients in our study because the patients in the prior study had existing gastrostomies. These mature gastrostomy tracts allowed larger lumen jejunal tubes (24 fr) to be placed provided simultaneous gastric decompression is not required (single lumen transgastric PEJ). In the event that both gastric decompression and jejunal feeding are required, the jejunal port is usually 12 fr in size. The population of PEG-J patients in our current study did not have pre-existing gastrostomies and hence received the standard 20 fr PEG with 9 fr J extension.
Reviewer B

Major Comment 1

a. “The study design is appropriate for this type of comparison, but is subject to inherent biases, especially in regards to patient selection. For example, patients in the PEG-J group were 10 years older and had significantly different indications (aspiration risk and GE cancer).”

We agree that a retrospective study is subject to inherent biases, especially because of non-randomization. All efforts were made to minimize bias selection by reviewing all consecutive patients who received endoscopic jejunostomies from Jan 2009 to May 2011 and applying the inclusion/exclusion criteria outlined in the methods section. We have added comments on the inherent deficiencies of a non-randomized retrospective study in the discussion section (page 13, last paragraph). With regards to indications for jejunostomy, the main indications for both groups were gastroparesis and high aspiration. GE cancer is actually higher in the DPEJ group, not the PEG-J group.

b. “Did any of the PEG-J patients initially fail placement of a D-PEJ?”

This question was also asked by reviewer A, comment 2a. Eleven of the failed DPEJ attempts underwent subsequent PEG-J placement. This has been added in the patients and methods section and the results section (page 4 bottom of paragraph 1, page 9 paragraph 2).

Minor Comment 1

“The authors mention that patients with a D-PEJ who require gastric decompression have a PEG placed in addition to the jejunal feeding tube. Although an acceptable approach, one wonders if the satisfaction of these patients would have been comparable to that of patients with 28/12 Fr. PEG-J tubes that allow for both feeding and decompression without the need for two abdominal incisions and two separate tubes.”

We agree with the statement that having a separate gastric decompression tube might be a source of patient dissatisfaction. We included in our discussion that in a previous study of DPEJ at our institution (Journal of Feeding 2010:85;980-990) that patient satisfaction with DPEJ was rated at 78%. This included patients who had gastric decompression PEGs. A 20 fr PEG decompression tube might provide better decompression than a PEG-J 28/12 fr, which has a 16 fr gastric port. We have added to the discussion section that a separate gastric decompression tube might be a disadvantage of the technique (page 13, paragraph 2).

Minor Comment 2

Table 1: consider deleting either the row “male” or the row “female”

We have changed this, as suggested.

Minor Comment 3

Figure 1: consider revising the axis legends

We revised the axis legends, as suggested.

Thank you for consideration of this manuscript.

Sincerely,
Todd H. Baron, MD