



SDI Review Form 1.6

Journal Name:	Journal of Cancer and Tumor International
Manuscript Number:	Ms_JCTI_35052
Title of the Manuscript:	Dp103 in Egyptian Patients with Breast Cancer: Prognosis to Lymph Node Metastasis
Type of the Article	Original Research Article

General guideline for Peer Review process:

This journal's peer review policy states that **NO** manuscript should be rejected only on the basis of '**lack of Novelty**', provided the manuscript is scientifically robust and technically sound.

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SDI Review Form 1.6

PART 1: Review Comments

	Reviewer's comment	Author's comment (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)
Compulsory REVISION comments	I agree with the author's conclusion that this is the first study of Dp103 serum level in breast carcinoma and controls, and this survey should be repeated in a larger scale. My other questions are: 1) In the "Subject", whether is this TNM staging cTNM or pTNM? Do the positive or negative (axillary?) lymph nodes all have pathological confirmation? Are there any M1 cases in this cohort? 2) In table 4, there are two columns both labelled as "adjacent normal breast tissue n=10", what is the difference? 3) Are the serum levels of Dp103 and MMP9 also measured in normal and benign controls? What is the baseline for Dp103 and MMP9 (in the controls)? 4) It appears that MMP9 showed a bigger difference between metastatic and non-metastatic breast cancer cases than Dp103? What is the explanation and significance of this?	1) All the TNM staging is cTNM before any procedure was done (surgery and therapy) and all axillary lymph node have pathological confirmation by the pathologists in National Cancer Institute by giving score for lymph node involvement from 0 to 4 and depending on this the classification was done. All cases were M0 there were not any metastasis. 2) In table 4 we did take two samples as control from each group (benign and primary breast cancer) to avoid any incorrect results and interference could happen (morphologically) as patient's age not really matched with different diagnosis. So for each patient group there was its control. 3) For Dp 103 serum ELISA kit was synthesized specifically for that paper and not done in other previous study, so we took control group (apparently healthy subject) as our reference range with wide assay range: 0.1ng/ml -40ng/ml and sensitivity: 0.043ng/ml. For MMP9 the kit that we worked with



SDI Review Form 1.6

		it which supplied form CUSABIO (http://www.cusabio.com/ELISA-Kit/Human-matrix-metalloproteinase-9Gelatinase-BMMP-9-ELISA-Kit-115199.html) also did not provide us with reference range and we took also the control as reference range with detect range 0.312 ng/ml-20 ng/ml and sensitivity 0.284 ng/ml. 4) Both parameters (MMP9 and Dp 103) did show increase in primary breast group than benign group and when subdivided according to lymph node involvement and both parameters did increase this may be due to signalling pathway and Dp 103 mechanism of action as its cause activation of both MMP9 and nuclear factor kappa. Hence, Dp 103 in primary breast cancer with positive lymph node predicts metastasis in these patients in future by direct involvement of MMP9.
<u>Minor</u> REVISION comments	Grammar and typo errors, for example: 1) "higher" not "high" in line 130 2) "ductal" not "duct" in line 67 3) Phrases and sentences mixed up in "methodology" in abstracts	All corrections were done.
<u>Optional/General</u> comments		