Re: 64258

World Journal of Clinical Cases

Dear Editor and reviewers,

We thank the editorial board for the comments about our manuscript (64258) entitled " Intestinal gangrene secondary to congenital transmesenteric hernia in children misdiagnosed with gastrointestinal bleeding: case report and literature review". The manuscript has been thoroughly revised according to the reviewer's comments.

We look forward to hearing your positive response to this revised manuscript.

Below are the answers to the reviewer's comments.

Response to Reviewer 1 (reviewer code: 05446731):

Comments 1. The authors collected 14 cases of congenital transmesenteric hernia since 2002. Why did the authors adopt such limitation as 2002?

Answer： Thanks for the suggestion, because the earliest reported literature consistent with our case was in 2002.

Comments 2 Because of a small numbers of collected patients, the authors should display data using median values rather than average values.

Answer： We sincerely appreciate the reviewer's helpful comments. It is really better to use median values rather than average values! We have revised and marked by RED in the revised manuscript.

Comments 3 The authors should add each explanation of A and B, in Figure1.

Answer： Thanks for the suggestion. We added the explanation of figure 1A and 1B, and marked by RED in the revised manuscript.

Comments 4 In Table 2, the data were shown with second decimal places. I think that the authors should clear numbers below decimal points.

Answer： We thank the reviewer's constructive comments. We were going to modify

it as you suggested, but another reviewer suggested that we remove table 2, and we deleted this part in the end.

Response to Reviewer 2 (reviewer code: 05185768):

Comments 1. Line 65 -please explain the typical and atypical symptoms of congenital transmesenteric hernia

Answer： Thanks for the suggestion. The symptoms of congenital transmesenteric hernia are depend on the diameter of the mesenteric defect. When the defect is too large or too small, the patient is usually asymptomatic. When the small intestine repeatedly passes through the mesenteric defect, the patient shows symptoms such as intermittent abdominal pain and abdominal distension. If the herniated intestine cannot relieve, it gradually develops into intestinal obstruction and leads to intestinal necrosis. If the herniated intestine relieve, it shows long-term intermittent abdominal pain with unknown causes or recurrent intestinal obstruction. Therefore the relatively typical symptoms of congenital transmesenteric hernia range from chronic mild abdominal discomfort to nausea, vomiting and abdominal distension. We have revised and marked by RED in the revised manuscript.

Comments 2. Line 85 – please mention the detail of vomiting such as bilious/nonbilious/projectile/coffee ground vomitus.

Answer： We thank the reviewer's constructive comments. He vomited once producing coffee-like substance, and the vomiting was non-bilious and non-projectile. We have revised and marked by RED in the revised manuscript (line101-102).

Comments 3. Line 91 – did you have abdominal x-ray? It will be better to present abdominal x-ray whether it showed the picture of small bowel obstruction. Abdominal x-ray is the initial investigation that is very useful for surgical conditions. Moreover, abdominal x-ray is friendly, affordable price and available worldwide. No need for

general anesthesia when compares with CT scan.

Answer: Thank you for your valuable suggestions. It's exactly what you suggested, abdominal x-ray is the initial investigation that is very useful for surgical conditions. However, after the formation of congenital transmesenteric hernia, the intestinal dilatation of obstruction is limited at the early time, and abdominal X-ray examination shows that there are few specific changes of intestinal obstruction such as liquid-gas plane.

Comments 4. Line 97 – duodenal ulcer was the consequence of HSP? If yes, it is rarely to recur after 1 year as HSP in children had a very good prognosis. This patient should not be DDX with DU from previous HSP.

Answer: Thank you for your valuable suggestions. Duodenal ulcer was not the consequence of HSP.

Comments 5. Line 111-116 – this lab might be unnecessary to present.

Answer: Thank you for your valuable suggestions. We removed these descriptions.

Comments 6. Line 121 – it will be better to focus the reason for re-imaging such as marked abdominal distension, marked pallor, etc. So that clinician will learn how to re-imaging even it is previously normal at first time. How long between first and second CT? Why did clinician not decide explore lap?

Answer: We sincerely appreciate the reviewer's helpful comments. The patient was admitted to the Pediatric Internal Medicine department at first, and there was no obvious abnormality on the first CT examination, but the patient's haemoglobin showed a downward trend. Combined with the patient's previous history of a duodenal ulcer, the primary diagnosis was gastrointestinal bleeding caused by a duodenal ulcer, so he was given conservative treatment, such as fasting, protecting stomach, rehydration and gastrointestinal decompression.

However, the patient's symptoms were obviously aggravated, the patients developed

marked abdominal distension, marked pallor. Physical examination: heart rate 150bpm, blood pressure of 88/32mmHg, abdominal tension, total abdominal tenderness, reduced bowel sounds. There was no bloody fluid in the nasogastric tube. Therefore, we no longer consider the suspicious diagnosis of gastrointestinal bleeding, but consider intra-abdominal bleeding, so we didn't take esophagogastroduodenoscopy, but CT re-examination (5h after the first) while preparing for emergency laparotomy. We have revised and marked by RED in the revised manuscript.

Comments 7. Line 134 – Did the authors put NG for the patient; to identify source of bleeding (intraluminal or extraluminal) and to release abdominal distension. Why did clinician not perform EGD if DU is the DDX?

Answer: We thank the reviewer's constructive comments. The primary diagnosis was gastrointestinal bleeding caused by a duodenal ulcer, so he was given conservative treatment, such as fasting, protecting stomach, rehydration and gastrointestinal decompression to identify source of bleeding (intraluminal or extraluminal) and to release abdominal distension. However, the patient's symptoms were obviously aggravated, and there was no bloody fluid in the NG. Physical examination: heart rate 150bpm, blood pressure of 88/32mmHg, abdominal tension, total abdominal tenderness, reduced bowel sounds. Therefore, we no longer consider the suspicious diagnosis of gastrointestinal bleeding, but consider intra-abdominal bleeding, so we did not undergo EGD, but CT reexamination while preparing for emergency surgery.

Comments 8. Line 135 – should add re-physical examination before re-examination of abdominal CT. It will be very useful for the clinicians who read this case report.

Answer: We thank the reviewer's constructive comments. Re-physical examination: heart rate 150 bpm, blood pressure of 88/32 mmHg, abdominal tension, total abdominal tenderness, reduced bowel sounds. We have revised and marked by RED in the revised manuscript

Comments 9. Line 173 – please add the characteristics of the vomitus

Answer: We thank the reviewer's constructive comments. We have revised and marked by RED in the revised manuscript.

Comments 10. Line 189-192 and line 214-218 – the authors should mention the presentation of progressive anemia or coffee-ground vomitus in the previous literature compare to the authors' case report. Is it common or rare? As authors mentioned mainly abdominal pain, abdominal distension and vomiting. Is there different in clinical presentation of this condition between children and adult?

Answer: We thank the reviewer's constructive comments. Actually all cases had the same symptom of abdominal pain and vomiting (14/14). All patients had non-projectile vomiting , 5 cases of bilious vomiting, 9 cases of non-bilious vomiting (1 case was chocolate-like, 1 case was water-like, our case was coffee-like). The symptoms of vomiting did not indicate congenital transmesenteric hernia, although the symptom of coffee-like was relatively rare in our case. There is no significant difference in the clinical manifestations of congenital transmesenteric hernia between adults and children. We have revised and marked by RED in the revised manuscript.

Comments 11. Line 223 – vomiting (13/14) be better to add detail of the vomitus (bilious, non-bilious).

Answer: We thank the reviewer's constructive comments. We have revised and marked by RED in the revised manuscript.

Comments 12. Figure 1 – asterixis or arrow at the lesions

Answer: We thank the reviewer's constructive comments. We have revised and marked by RED in the revised manuscript.

Comments 13. Table 1 – many typo errors (shock-like or shock like, vomiti, 1 days)

-It will be good to add symptom of anemia, Hb drop in column symptoms (should change the name of column to symptoms and signs). As authors conclude that CT is helpful for improving the accurate preoperative diagnosis, it will be good to put the column imaging in this table if possible. The thing that I am very concerned that this will mislead the reader in management especially the emergency condition that need explore lap to delay for investigation with CT scan.

Answer: We thank the reviewer's constructive comments. We are very sorry to made these handwriting mistakes. Although we emphasize the importance of CT in the correct preoperative diagnosis of congenital transmesenteric hernia. However, only if time permits, CT examination should be carried out, which does not mean that all patients must have CT examination. If the patient's condition progresses rapidly, emergency laparotomy can be performed directly to avoid delay in rescue due to CT examination. We have revised and marked by RED in the revised manuscript (line 222-227).

Comments 14. Table 2 is unnecessary, the authors can put some statistic data in the text instead.

Answer: We thank the reviewer's constructive comments. We have removed Table 2 in the revised manuscript.

Once again, thank you very much for your comments and suggestions.

Best wishes.