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SPECIFIC COMMENTS TO AUTHORS

The proposed modified score is interesting and probably of good clinical value. Here are some remarks:

1. In the abstract it is stated that PI is a pathognomonic radiologic sign of bowel ischemia, this not true, like the authors say immediately after.

2. I guess that pneumoperitoneum is a sign of abdominal pathology, so point the first criterium for modification of the score is not respected in this case.

3. Table 1: imaging studies did not not rule out perforation.

4. Table 1: there were dysphagia at the onset of symptomatology.

5. Table 1: PI is observed in a wide range of situation, mat also be idiopathic, it is very difficult to rule out alternative causes.

6. There is no reference for table 1 in the text.

7. Pneumoperitoneum is underestimated, probably the authors refers it to PI, in this case there should be a minimal discussion about it.

8. There are small writing errors (some spaces are missing between words).

AUTHOR'S POINT TO POINT REPLY

1) Many thanks for comments. We agree that it is not pathognomonic, and revised as "suspicious for" bowel ischemia.
2) Yes, pneumoperitoneum is indeed a sign of abdominal pathology. Thus, we subjected our patient extensive battery of tests along with placing her nil by mouth for few days. In particular, she had no abdominal pain or fever or nausea/vomiting etc symptoms. Her physical exam did not reveal abdominal tenderness. Her serum investigations did not reveal elevated inflammatory markers, and her blood gases were normal. Further, CTAP did not reveal appendicitis, colitis, pelvic inflammatory pathology, enteritis, cholecystitis, or any

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other pathology. As her CTAP also did not detect any possible aetiology to account for pnematosis coli, we were than convinced that probably this could be due to recent prednisolone prescription. As her abdomen was soft with no abdominal symptoms, we scored as "No" for this question.

3) This is interesting comment. In a way, you are justified in concluding that imaging 'did not not rule out" a perforation. In our opinion, imaging findings has to be considered along with clinical and serological findings. Overall, after a comprehensive work-up, no aetiologic diagnosis was made that could contribute to pneumatosis coli. Further, there was no evidence of contrast leak or mural defect on serial imaging studies. It is possible that she had perforation and imaging did not detect it, i.e. CTAP with NGT contrast lacked sensitivity to pick up the hollow viscus perforation. In our experience, when CTAP lacks sensitivity, other adjunct tests and tools would be sufficient to warrant a concern and guide clinical decisions, especially as delay in source control is detrimental to clinical outcomes. However, despite a suspicion and active efforts to identify possible hollow viscus perforation, we did not find any evidence. Thus, on a balance of probabilities, we conclude that "imaging studies" ruled out perforation. However, we agree with you that such opinion was not solely based on imaging, but also based on serological tests and clinical parameters. Thus, our modified Naranjo score has both (a) symptoms and signs and (b) serum inflammatory markers included in the scoring system.

4) Our patients' dysphagia was long standing that lead to her malnutrition and a diagnosis of NMO on a background of eye symptoms. As a result of emaciation, nasogastric tube feeding was commenced and a radiograph was done to confirm tube placement. In our opinion, dysphagia, though a symptom, did not contribute to pneumatosis coli. In evidence of other clinical features of

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mediastinitis, pleural effusion, tachypnea, etc; we rule out esophageal perforation either. Thus, on a balance of probabilities, the pneumatosis coli was not related to dysphagia, but to other aetiology; which in our patient is likely to be recent prescription of prednisolone.

5) Indeed, there is a wide range of situations. Besides perforated viscus, alternative causes for benign PI include obstructive lung diseases, drug use, systemic disease: lupus, scleroderma, AIDS etc. The presence of these alternative causes would qualify for a "yes" in this scoring rubric. In our patient, the investigations were guided by clinical presentation and not done for the purpose of publishing "a case report", as the decision to report the case was in retrospect and not prospective. Further, as clinical presentation did not warrant a luminal endoscopy or diagnostic laparoscopy; we did not do such invasive investigations.
6) Thank you, we have included the reference for Table 1
7) Agree, due to word limit, we are unable to expand on the discussion on pneumoperitoneum and PI.
8) We have corrected the writing errors, thank you!