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PEER-REVIEW REPORT

Name of journal: World Journal of Gastrointestinal Surgery

Manuscript NO: 58412

Title: Risk factors of postoperative stoma outlet obstruction in ulcerative colitis

Reviewer's code: 03475767
Position: Peer Reviewer
Academic degree: MD
Professional title: Professor
Reviewer's Country/Territory: Italy
Author's Country/Territory: Japan

Manuscript submission date: 2020-08-03
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Reviewer accepted review: 2020-08-03 11:15
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Scientific quality	[ ] Grade A: Excellent [ ] Grade B: Very good [ ] Grade C: Good [Y] Grade D: Fair [ ] Grade E: Do not publish
Language quality	[ ] Grade A: Priority publishing [Y] Grade B: Minor language polishing [ ] Grade C: A great deal of language polishing [ ] Grade D: Rejection
Conclusion	[ ] Accept (High priority) [ ] Accept (General priority) [ ] Minor revision [Y] Major revision [ ] Rejection
Re-review	[Y] Yes [ ] No
Peer-reviewer statements	Peer-Review: [Y] Anonymous [ ] Onymous Conflicts-of-Interest: [ ] Yes [Y] No

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SPECIFIC COMMENTS TO AUTHORS

This is a well written manuscript about Stoma outlet obstruction (SOO)in Ulcerative Colitis (UC) surgical patients. However, the retrospective nature of the study (12 years period) appear as a strong limitation and some points should be addressed: 1. Materials and Methods: "Cases without CT images, regardless of a clinical presentation suggesting SOO, were deemed not to have SOO". As reported it appear as a bias: as SOO is a clinical condition and complication, and clinical examination can be almost enough to diagnose SOO. Furthermore, during a 12 years retrospective period, in absence of a specific clinical protocol of a prospective research, who tell the readers that every patient with symptoms and signs of SBO undergone CT scan!? M&M section should clarify this aspect, and it is necessary to report how many patients showed clinical SOO in absence of a CT scan performed. 2. M&M: "A loop ileostomy was consistently created at the marked site of the lower-left quadrant". I believe it is one of the most interesting issue of this research: in performing an IPAA, the small bowel has to follow the superior mesenteric vessels cord, and this is on the right side of the abdominal median line. So to avoid traction usually a right loop ileostomy is necessary. I believe the data about IPAA group are to be more clearly reported: a new table reporting all the surgical and clinical data about this subgroup of patients should be created to let the reader able to easily understand if the different reconstruction had a role in the development of SOO. Furthermore, I hope it is possible for you to add also the mean distance of the ileostomy from the pouch inlet (or from Treitz ligament) and the percentage of IPAA dehiscence in this subgroup as well as the precise way SOO was solved. 3. "higher maximum stoma drainage concentration" please clarify: is it the maximum output reported in the inpatients chart? At which post-operative day? I believe the mean output/24h is more appropriate in order to answer the whole question. 4. "Finally, the anterior and posterior sheaths of the rectus abdominis were sutured to reduce the thickness of the rectus

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abdominis. They were then fixed to the serosa and muscle layer of the intestine using four stitches". This procedure is not standardized and not performed in any surgical Center world-wide, so I believe the incidence of other postoperative complications of the ileostomy (i.e. ileostomy prolapse, incisional peristomal hernia, specific complications found at operation of ileostomy closure) should be reported. 5. Discussion: "A few studies have reported that diverting the stoma reduced…..". in this position "the" is not necessary. 6. Discussion: "The causes of SOO have been reported as torsion, adhesion below the abdominal wall, or stenosis of the penetrating part of the ileostomy[18,24]. In this study, it was difficult to evaluate torsion or adhesion below the abdominal wall penetrating part of the ileostomy. This is because CT images were not taken in the cases that did not have SBO and it was not possible to make comparisons between the two groups". This explanation you give is really unconvincing. Please try to revise the data and to report in results section or in tables the percentages of the more probable causes of SOO in your cohort, even in relationship to the way SOO was solved. 7. Discussion: "Therefore, it is expected that the surrounding pressure will easily affect it, and it will be particularly noticeable in the penetration stage. If high-output stomas appear in such situations, even if there is no apparent stenosis, the pressure tends to cause passage obstructions in the penetrations, which can result in SOO". Please clarify the last sentence: which pressure do you mean?.

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Author's Country/Territory: Japan

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Language quality	[ ] Grade A: Priority publishing [Y] Grade B: Minor language polishing [ ] Grade C: A great deal of language polishing [ ] Grade D: Rejection
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SPECIFIC COMMENTS TO AUTHORS

Dear authors, 1. In abstract in result section "lower total dose of steroid" section, 0 mg vs 0 mg is given in bracket. Kindly correct it. 2. Higher maximum stoma drainage concentration – word concentration needs to be replaced by volume here. 3. It is interesting to know about the way you create intestinal stoma, in our own experience we create cruciate incisions over rectus sheath and after entering peritoneum, two fingers are used to dilate the abdominal wall trephine to check adequacy, then after four corners of anterior rectus sheath (created by cruciate incision) are sutured with absorbable sutures to ileal wall and margins of ileum to skin after adequate pouting. In our experience for temporary stomas this is good enough diameter and hardly we have found stoma obstruction at abdominal wall level. This comment is just to share our experience with you. This is are the only minor revisions from my side. Thank you for sharing your work.