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World Journal of Clinical Cases

Specific Comments To Authors: Extend my gratitude to all authors for making an attempt to bring this uncommon surgical emergency to our attention. The centre video quality is good, however both in the manuscript and in the video failed to address how the mesocolic defect was managed. Regrettably, the wall manuscript requires a lot of language polishing, and a few of the terminology used / sequence of words not up to the International standard. I wish them well

Answering Dear Editors:

Thank you for the constructive feedback on our manuscript. We wish to resubmit a revised version of our manuscript, “**Transverse mesocolic hernia with intestinal obstruction, a rare cause of acute abdomen in adults: A case report with video.**” The manuscript ID is **86629**.

We have addressed the feedback of the editors and reviewers in the revised manuscript, and appropriate changes have been made accordingly. All changes in the revised manuscript have been highlighted in yellow. All authors have read and approved the revised manuscript for submission.

We hope you find the revised manuscript suitable for publication in the *World Journal of Clinical Cases*. Again, we thank you for your consideration. I look forward to hearing from you.

Sincerely,

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The patient underwent emergency laparoscopic surgical exploration. Intraoperatively, the small intestine was discovered to be herniated from the mesocolon defect below the transverse colon to the lower part of the liver and gallbladder and was trapped by an adhesive band between the liver and duodenum. The entrapment intestinal obstruction involved a trapped small intestine and mesocolon, a loosened adhesive band, and the entrapment of the small intestine because of the mesocolon defect below the transverse colon. The defect area of the transverse mesocolon was approximately 25 cm². The blood

flow within the small intestine recovered well, and no intestinal resection or anastomosis was required (Figure 2). The small intestinal obstruction in this patient was closely related to adhesive tape entrapment. An intraoperative evaluation revealed that the mesocolic defect in this patient was large and that the possibility of recurrence of small intestinal obstruction was minimal, so the decision was made not to repair the mesocolic defect during the operation.

Few mesocolic hernias have been reported. Congenital mesocolic hernias have three types. The first two are the right and left types, comprising 25% and 75% of all cases, respectively. The third type is extremely rare and known as a transverse mesocolic hernia^[7].

A clear preoperative diagnosis is difficult in most patients with internal abdominal hernias because they have no obvious symptoms or signs. These hernias manifest mostly as abdominal pain, abdominal distension, and vomiting and cannot be distinguished from other acute abdominal diseases. Abdominal CT is a useful auxiliary diagnostic technique. In the patient presented in this report, CT revealed local intestinal dilation in the abdominal cavity, intestinal tube wall thickening, an abnormal location and disordered arrangement of the small intestine, intestinal wall thickening, oedema, and mesangium above the transverse colon near the hepatoduodenal ligament and gallbladder. The small intestine is not typically located in this region. Therefore, this patient underwent an emergency laparoscopic operation to investigate an intraperitoneal hernia with small intestinal obstruction. For intraperitoneal hernias with mesocolic defects, most surgeons will choose to close the defect^[10]. However, the small intestinal obstruction was closely related to adhesive tape entrapment in this patient. An intraoperative evaluation revealed that the mesocolic defect in this patient was large, and the possibility of recurrence of small intestinal obstruction was minimal, so a decision was made not to repair the mesocolic defect during the operation.

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10 Montovano M, Chernock B, Merchant AM, Shapiro M, Oliver JB. The rare middle mesocolic hernia *Am Surg* 2020;88**:1346-1348. [PMID: [32856934](#) DOI: [10.1177/0003134820945278](#)]**