Author's response to reviews

Title: Acute mesenteric ischaemia and duodenal ulcer perforation: A unique double pathology

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Author's response to reviews: see over
Dear Chief Editor (BMC Surgery)

In response to the concerns raised by Mr Usama Ahmed Ali

1. The abstract conclusion has been amended so it no longer implies endoscopic repair of the duodenal perforation was a primary option.

2. Further information has been added to the case report detailing the patient’s medication history and key details in particular her vascular medical history, evidencing that chronic mesenteric ischaemia was an unlikely contributing factor to her duodenal ulcer formation and perforation. Patient never lost any weight prior to her admission with the current presentation.

3. Additional information regarding the nutritional status of the patient prior to and on admission has been added to the case report section.

4. Distal 212 cm (162 cm + 50cm) of small bowel was ischaemic. Anatomically the ischaemia was in superior mesenteric artery territory.

5. Abbreviation ‘ALT’ has been written in full

In response to the concerns raised by Mr Werner Draaisma

1. As the patient had severe acute renal impairment, we were unable to use contrast for any imaging and therefore were unable to do an angiogram. A non-contrast abdominal CT was initially done, and it was later felt a CT abdomen with contrast outweighed the possible risks of worsening renal impairment. Neither CT scan showed any evidence of bowel ischaemia and so risking further renal impairment to do an angiogram was felt to be inappropriate, and it was decided to take the patient straight for diagnostic laparoscopy /laparotomy.
2. The celiac trunk and SMA were examined during the laparotomy. The celiac trunk felt normal, however, because of atherosclerosis the SMA was very weak and almost non-pulsatile.

3. There was a period of 12 hours between the patient presenting to A&E and her going to theatre. This delay was due to the patient being very unstable, and the surgeons felt that taking her straight to theatre would have been more detrimental than intensive medical support, especially considering there was no clear evidence of bowel perforation or ischaemia from any of the initial imaging.

4. The ascitic tap was performed to look at the type of ascitic fluid and to rule out spontaneous bacterial peritonitis. In addition there was no evidence of perforation on CT scan and hence ascitic tap was performed.

5. The duodenal perforation was initially closed with an omental patch during the first laparotomy. During the patient’s endoscopy for a naso-jejunal tube insertion it was noted that the perforation had not fully healed and it order to facilitate recovery it was clipped.

In response to the concerns raised by Mr Burkhard von Rahden

1. We feel surprised by the comments that this case is not interesting and would like to emphasize that it is a rare occurrence to have dual pathology in the same patient and by reporting this case report it may help in management of patients presenting with dual pathology. The other two reviewers have also appreciated our efforts to report this case.
The case report has been amended where necessary to address the concerns raised by the reviewers and improve understanding of the case.

We will appreciate if the revised manuscript can be considered for publication in the journal

Kind regards

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