Author's response to reviews

Title: The Management of Large Perforations of Duodenal Ulcers

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Author's response to reviews: see over
## Clarifications to the Referee’s comments

**Title:** Giant Perforations of Duodenal Ulcer

**Reviewer 1**  Moshe Schein

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<th>Major Compulsory Revisions</th>
<th>Clarifications</th>
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<td>1. I have a problem with the definition of a &quot;giant&quot; ulcer. For us in the West a giant ulcer is something larger than 2-3 cm'. A 1 cm' ulcer--used by the authors is &quot;big&quot; but not giant. I would suggest thus change the title to &quot;large...&quot;.</td>
<td><strong>Giant duodenal ulcers</strong> are ulcers that are at least 2 cms in diameter. This reference has been added to the revised manuscript. However, as mentioned in the manuscript, there is no definition of <strong>giant perforations</strong> that occur on a background of duodenal ulcers (of any size). This is what we have tried to highlight in the present report that no clear cut definition exists of <strong>giant perforations of duodenal ulcers</strong> (as contrary to <strong>giant duodenal ulcers that perforate</strong>). However, the title has been changed to “The management of Large Perforations of Duodenal Ulcers” and suitable changes made in the text.</td>
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<td>2. It is obvious that the bigger is the perforation, the more difficult it is to fix it and the higher is the potential postoperative morbidity. I would like to see the breakdown of the ulcers according to sizes: how many were larger than say 3 cm? And what were the results in such subgroup? (why not divide to subgroups of &lt; 1 cm, 1-2 cm', 2-3 cm, &gt; 3 cm'.</td>
<td>The point is well taken, and the revised text contains the classification of perforations into small (less than 1 cm), large (1 cm – 3 cm), and giant (more than 3 cms).</td>
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<td>3. The authors described doing omental patch according to &quot;Cellan Jones.&quot;. We need a reference to support a claim that omentopexy was described first by these authors and</td>
<td>These references have been added - 1. Cellan-Jones CJ. A rapid method of treatment in perforated duodenal ulcer. BMJ 1929; 36, 1076 - 7. 2. Graham RR. The treatment of</td>
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not Roscoe Graham – the Father of "Graham patch."

**4.** Please describe accurately your omental patching technique in the material and methods section.

Added.

**5.** Did the omentopexy in any of the patient consisted of suturing the omentum ABOVE a sutured perforation?

No. This has also been added in the text.

**6.** Was there any case with a truly perforated giant ulcer involving both the anterior and posterior duodenal wall? These are the type of ulcers with mandate antrectomy.

No, we did not encounter any such case having both - anterior and posterior ulcers. This information has been added to the revised manuscript.

**7.** The authors could mention that Billroth I reconstruction is yet another option after antrectomy for the difficult duodenum.

We have already mentioned that reconstruction after antrectomy can be as Billroth I or Billroth II.

**8.** The list of references is poor and limited. 4 out of 6 references are from India. Why? Surely there are more relevant references in the literature!

We performed an exhaustive review to identify any relevant literature. However, it is this paucity of data on the topic that has prompted us to review our experience in this area and present it, so that further work may be stimulated in the field. However, we were able to come across another reference dealing with giant perforations - McIlrath DC, Larson RH. Surgical management of Large Perforations of the Duodenum. Surg Clin North Am 1971; 51: 857 – 61 – and this has been added to the revised text.

**Reviewer 2 Jyrki JT Mäkelä**

**1.** Introduction: I don’t regard suturing of the omentum to the nasogastric tube as an adequate operation method. This detail must be omitted (the same in discussion).

We have mentioned this in our manuscript for the completeness of discussing the topic, since it has been previously described in literature as a method of dealing with such large perforated duodenal ulcers. Surg Gynecol Obstet 1937; 64: 235 – 8.
This was published in the British Journal of Surgery (in 1993), which is one of the leading surgical journals of the world.

2. **Patients and Methods:** Are the perforations really measured during operations? This detail must be reconsidered. More exact analysis of risk factors should be added. The statistical analysis must be specified.

   The study is a retrospective one, where the sizes mentioned in the operative notes have been accepted and analyzed without any changes. However, it is accepted that at many hospitals the sizes are often not measured.

   The statistical analysis has been strengthened in the ‘materials and methods’ section.

3. **Results:** In text: The postoperative morbidity and mortality (causes of death) must be more carefully presented. Maybe a table could be more informative. Risk factor analysis must be added.

   Rather than giving another table, we have taken care of these details in the text of the revised manuscript. These references have been added and updated in the revised manuscript.


4. **Discussion:** One paragraph concerning factors that predict morbidity and mortality in patients with perforated peptic ulcers must be added.

   You have 17.5% mortality in patients with giant perforations. Relaparotomy must be considered in patients with

   Added.

   Yes. We agree that relaparotomy is desirable in patients with continuous peritonitis. As a policy, we do not wait and watch, but prefer to re-operate all such cases. However, since this manuscript stresses on the size of the perforations.
| continuous peritonitis. You cannot only wait and see. | perforations, we have not gone into the details of management of such patients and their outcome, as this unnecessarily dilute the message as well as content of our presentation |

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