Title: Acute jejunoileal obstruction due to a pseudopolyp in a child with undiagnosed Crohn disease

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Author's response to reviews: see over
Submission of Revised Manuscript: Acute jejunoileal obstruction due to a pseudopolyp in a child with undiagnosed Crohn disease. A case report

Dear Editor,

Permit me to thank you for the careful and thorough review of my manuscript entitled “Acute jejunoileal obstruction due to a pseudopolyp in a child with undiagnosed Crohn disease. A case report”. Having read carefully the suggestions made by the reviewers, I performed all necessary changes which are included in the point-to point answer following. Some language corrections were performed in the text.

Reviewer: Mohamed Fahmy

1. First of all as the appendix included in the specimen which is 45cm, so I think the whole brunt of the disease is ileal and not ileojejunal as mentioned by the author in many parts of the report, and this should be corrected in the whole report.
Herein are the suggested corrections:

Title: ACUTE JEJUNOILEAL (Intestinal) OBSTRUCTION DUE TO A PSEUDOPOLYP IN A CHILD WITH UNDIAGNOSED CROHN DISEASE. A CASE REPORT

Abstract
A child suffered from undiagnosed Crohn disease (CD), presented with acute abdominal (Intestinal) obstruction, due to a big pseudopolyp in the jejunoileal area (Ileum) At laparotomy, a jejunoileal (Ileum) segment of 45 cm containing multiple damages of the small intestine was excised and a primary end small intestine was excised and a primary end small intestine was excised and a primary end small intestine was excised and a primary end anastomosis was done. We couldn’t find a similar case from the international literature.

I think that the reviewer has right because we did not define accurately the presented pathology. The appendix found to be atrophic while 130cm far from the ileocecal valve, that means near to ileojejunal part of the small intestine the multiple inflammatory damages of the intestine were found. The rigid and thickened mass (inflammatory ileal portion) extended for 30cm. We performed resection of the macroscopically ill ileojejunal part of the small intestine (the length of resection was about 45cm) as well as appendicectomy. That the reason that we have chosen the term jejunoileal and we think that after these explanations the reviewer will agree.

Corrections in the text:

Case Presentation, third paragraph:
The patient was operated and a 30 cm small bowel multiple damages were found. These included macroscopically a rigid and thickened mass (inflammatory ileal portion), creeping fat, multiple granulomas in external intestinal surface with ulcers, two of which had parietal ruptures with fluid escape. A resection of 45 cm ileo-jejunal portion including
all intestinal damages was made and a primary end to end ileo-jejunal anastomosis completed the operation.

Changed as

The patient was operated. Intraoperatively the appendix found to be atrophic, while 130cm far from the ileocecal valve we found a rigid and thickened mass (inflammatory ileal portion), creeping fat, multiple granulomas in external intestinal surface with ulcers, two of which had parietal ruptures with fluid escape. We performed appendicectomy and a resection of 45cm of the ill ileo-jejunal portion including all intestinal damages along with a primary end-to-end ileo-jejunal anastomosis.

2. Case presentation
A 12-year-old boy was brought to the emergency Department with acute abdominal pain lasting 12 hours, also abdominal distention, absence of defecation for two days (Absolute Constipation), vomiting and fever of 38,50C. When examined he had a general abdominal tenderness. White blood cell count was 17,5k/ml with 85, 5% neutrophils, hemoglobin was 10,9 gr/dl, hematocrit 34,7% and platelets 820 k/ml. Abdominal x-rays showed air-fluid levels and abdominal ultrasound examination revealed a solid intraluminal pattern (figure 1). Individual history referred intermittent abdominal pain for a period of 6 months. More information, such as diarrheas for 6 months, quick tiredness, no mood to play, laziness and paleness, were given postoperatively.

Case Presentation, first-second paragraph:
The suggested corrections were performed.

3. The statement (One month later, endoscopic examinations showed granulomas and other Crohn’s damages from the stomach and in the small and ascending intestine.) is not correct because how the author can examine the small intestine endoscopically, the statement (small and ascending intestine) can be replaced by the stomach and colorectum.

By saying endoscopic examination of the small intestine we mean the first part of duodenum which we can easily examine in upper gastrointestinal system endoscopy. Taking under consideration the reviewer’s suggestion we corrected our phrase as he proposed.

4. In Discussion (CD can affect any part of alimentary tract from the mouth to the anus, with most common place the terminal ileum. Approximately, 15% of all patients with CD are children. There are special pathological features of CD from Ulcerative Colitis). This statement needs reference.

We placed the relative reference.

Reviewer: Dimitrios Smailis

No changes or definitions were requested.

Closing, I am looking forward for your positive answer and I remain,
Yours Sincerely,

Dimitrios Filippou, MD, PhD
General surgeon, vis. Professor University of Athens