Author's response to reviews

Title: Intussusception of the small bowel in the elderly secondary to malignant metastases: a report of 2 cases.

Authors:

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Author's response to reviews: see over
Dear Sir/Madame,

We would like to thank you for your time and effort in examining our paper. We are also thankful for the instructions and recommendations by the editorial board and the reviewers. All the recommendations/suggestions were included in the text (highlighted segments).

Specifically:

**IN GENERAL:**
1. Patient ethnicity was included in both cases.
2. Grammatical and syntactical errors were corrected.

**REVIEWER No. 1**

**Abstract:**
1. Para 3 symptoms and signs will be signs and symptoms
   Authors response: Symptoms and signs were changed to “signs and symptoms”

**Text:**
1. Para 3: Add “with” and make sentence as she presented with bone metastases.
   Authors response: Changed to “…presented with bone metastases”

2. Para 4: Reframe ileum were resected with ileum was resected.
   Authors response: Changed to “…was resected”

3. Para 5: double jejunojejunal intussusception will be jejunojejunal intussusception.
   Authors response: We described it as “double jejuno-jejunal intussusception” because the affected segment was doubly folded (intussusception within the intussusception) into the adjacent jejunal loop.

4. Para 5: was the cause of intussusception in. end the sentence properly.
   Authors response: Changed.

5. Para 7: provided that the state of health of the patient allows it should be in brackets (...).
   Authors response: The phrase was put in brackets.

**TEXT**
1. This is not a SERIES; a series must have at least 5/7 cases .please rename the article.
   Authors response: Title was changed to: “A report of 2 cases”

2. The abstract may be described in a continuum as “our first patient...Our next/second patient presented with.... .
   Authors response: Changed

3. Do you really need the line “Although CT scan.... etiologic agent” in writing conclusion of abstract?
   Authors response: Technically it is not necessary to include this segment, but we believe it should be included, since it illustrates the points made in our conclusion.

4. Reframe breast lobular carcinoma With Lobular carcinoma of Breast.
   Authors response: Done

5. Add the word metastatic in demonstrated melanoma of the small bowel.
   Authors response: Done
6. How is the diagnosis done by CT scan in second case?
Authors response: Computed tomography showed a signet-ring unilateral thickening of the intestinal wall (possibility of lumen-within-lumen), which, according to the radiologist, was suggestive of intussusception.

Figures (legends)
1. Figure 4 showing CT scan may be labeled with an asterix(⁎) showing diseased segment. If you have a coronal CT/MDCT/ few others “cuts” this can show us the classic diagnosis.
Authors response: The pertinent part of the image was labeled by a circle, and explanatory text was added in the main text and figure legend.

2. Figure 2 is excellent !!. Can you include figure 3 as inset?
Authors response: Thank you. Figure 3 was inserted into figure 2, and figure legend was modified.

Case 1. We are interested to know
a. Any History of previous bowel surgery/Abdominal surgery
Authors response: The patient had no history of prior abdominal surgery.
b. Mention that she had mastectomy 3 years ago in text; not only in abstract.
Authors response: Done
c. Apart from the mesenteric nodules were there any signs of peritoneal carcinomatosis?
Authors response: No signs of peritoneal carcinomatosis were shown on CT scanning or intraoperatively.
d. Were there any pelvic/subphrenic deposits?
Authors response: No pelvic/subphrenic deposits were found.
e. Did the bone scan (during follow up adjuvant therapy) pick up any abdominal disease as she had 3 episodes of obstruction in the last year?
Authors response: Bone scintigraphy was negative for abdominal disease.

Case 2
a) What were the CT suggestive features that suggested the tell tale diagnosis of an intussusception? You have reported only An intestinal loop with an abnormally thick wall (approximately 10 mm) with dilatation of the stomach and the small bowel full of liquid up to the proximal ileum. These findings that you have mentioned constitute a small bowel obstruction due to a cause in the bowel wall (e.g. A small bowel adenocarcinoma). Please specify what you have obtained in CT to suggest a diagnosis of intussusception?
Authors response: Computed tomography showed a signet-ring unilateral thickening of the intestinal wall (possibility of lumen-within-lumen), which, according to the radiologist, was suggestive of intussusception.

b) What is a DOUBLE jejunojejunal intussusception?
Authors response: The affected segment was doubly invaginated (intussusception within the intussusception) into the adjacent jejunal loop. Perhaps “compound” would be a better term.

Discussion
a) Reference of Barbette from Amsterdam was the first person to refer to intussusception in 1674.
Authors response: Done
b) Year and reference of “The first successful…. Sir Jonathan Hutchinson.”
Authors response: Done
c) Why use Barium films in comparison to gastrograffin films which are much safer in obstructing or perforating bowel lesions?
Authors response: Barium film is the method described in the textbooks, so we included it despite our agreement on gastrografin being safer in suspicion of perforation. Of course, the patient’s condition dictates the feasibility of any diagnostic study.

d) What was the type of metastasis of melanoma ploypoid or submucosal implant?
Authors response: Polypoid.

REVIEWER No.2:

a. Authors should mention how common intussusception as a cause of intestinal obstruction (instead of saying it as very common).
Authors response: It was already mentioned for adults: 1% of intestinal obstructions. We also stated that it is an uncommon situation in adults. Regarding children, we added that it is the most common cause of intestinal obstruction.

b. It was not understandable how they could do an end to end anastomosis for a lesion which was 10cm from ileo-cecal valve in the first case?
Authors response: Due to the fact that the patient had advanced disease (bone metastases) and was of advanced age, we decided to perform an end-to-end anastomosis, in order to treat the intestinal obstruction.

c. The more common etiology like NHL as a cause of adult intussusception has not been mentioned at all!
Authors response: It is true that we did not include the most common neoplastic causes of intussusceptions in adults, because we focused on the causes in our 2 cases, and also for economy of space.

d. About the second case they have once mentioned that the patient was admitted initially in the internal medical department, but during discussion, the statement was different
Authors response: Both patients arrived in the emergency Department which is a common area for surgical and internal medical cases. The first patient was admitted to our clinic, since his symptoms were more frank, and the second patient was admitted for observation to the Internal Medicine clinic, where we were invited for surgical consultation, and upon diagnosis he was transferred to our clinic.

e. No information is given about mesenteric lymph node
Authors response: No infiltrated mesenteric lymph nodes were found in the operating room and after histologic examination.

We are at your disposal for any clarifications/corrections necessary, and we look forward to your response.

Yours truly,

Spiridis Charalambos,
Kambardous Apostolos,
Ntinas Achilles
Papadopoulos Savvas,