Author's response to reviews

Title: Bladder augmentation with continent stoma: a surgical option by association between Mitrofanoff's principle and Monti technique.

Authors:

Marcelo F Cassini (marcelo.cassini@globo.com)
Antonio A Rodrigues Jr (aantunesrj@yahoo.com.br)
Silvio Tucci Jr (stuccijr@yahoo.com.br)
Adauto J Cologna (ajcologn@fmrp.usp.br)
Rodolfo B Reis (rbreis@keynet.com.br)
Antonio CP Martins (antonio@capovox.com.br)
Haylton J Suaid (hjsuaid@fmrp.usp.br)

Version: 6 Date: 10 July 2010

Author's response to reviews:

Cover letter:

Dear responsables,

We made some suggested changes, and we would like to justify the items specifically listed:

Reviewer's report

Title: Bladder augmentation with continent stoma: a surgical option by association between Mitrofanoff's principle and Monti technique.

Version: 3 Date: 1 June 2010

Reviewer: Anwar Naqvi

Comments to authors:

This is a good case report demonstrating the solution to the problem of short appendix which we came across not frequently. If we take out stoma through umbilicus, this combination become more logical otherwise skin based tube can be used as an alternative to this procedure as popularized by CR Woodhouse.

We agree, but the stoma at the umbilicus is hidden and leaves the abdomen more aesthetic, despite the median scar; besides the tube made by a flap of skin, as popularized by CR Woodhouse, present similar risks of complications (necrosis and stenosis) as compared to the association described in our study.

Quality of written English: Needs some language corrections before being
Published
Ok!

Declaration of competing interests:
'I declare that I have no competing interests'
We agree and have done the inclusion.

Reviewer's report

Title: Bladder augmentation with continent stoma: a surgical option by association between Mitrofanoff's principle and Monti technique.

Version: 3 Date: 25 May 2010
Reviewer: Frank Van der Aa

Comments to authors:

The authors report a case of continent vesicostomy with bladder augmentation using en combination of appendix (Mitrofanoff) and ileum (Yang-Monti).
In general, this is an interesting case. Surgeons who are familiar with this type of surgery ofter have to be inventive during their work in orde to get things right.
The association of the Mitrofanoff with the Yang-Monti technique is therefore not enterily suprising. I a similar way, the "double Monti" technique puts two Yang-Monti channels in a line. The authros should mention this technique in their manuscript.

Thank you for the comments.
We make it clear in the text that this was not a description of a new technique, but an association between two techniques already well established.
Regarding the “double Monti”, as well suggested, we mentioned this technique in the manuscript.

Some questions about this case remain unanswered:

Why does the surgeon decide to prolonge the channel with a Monti, instead of making a right fossa stoma?

Sometimes the appendix can’t reach the skin even at the right iliac fossa, in obese patients. The umbilicus, already crosses the subcutaneous tissue and muscle aponeurosis facilitating the procedure, unlike when we put the stoma in the right iliac fossa.
Finally, the stoma at the umbilicus is hidden and leaves the abdomen more aesthetic, despite the median scar.
Why doesn't the surgeon prolong the Mitrofanoff with a stapled/tapered part of caecum?

It's an interesting alternative too, but in our service we performed a routine use of the ileum. Complications involving the cecum are more severe and feared than when the ileum is used.

If the author decides to take a part of ileum, why doesn't he make a spiral Monti and checks if the length of this single conduit is not enough?

It's another and interesting alternative. We would like to describe a different choice of existing ones. We believe that the anastomosis of the appendix in the bladder creates an excellent antireflux valve with better continence rates than when using the isolated Monti.

Although no large datasets compare these different techniques, it is expected that a mid-conduit anastomosis, certainly when you use different parts of bowel, is at risk for developing catheterization problems (stenosis or pouchlike dilatation).

This type of surgery has its complications rate. Logically when more anastomosis are made, higher are the risks of complications. Basic principles should be observed, as the tension of the anastomosis and viability of the tissue (perfusion). Today we have 10 patients operated using this combination, with no significant increase in complications rate or difficulty for catheterization.

P.S. the manuscript needs proofread for grammatical and typographical errors.
Ok! Thank you very much.
Quality of written English: Not suitable for publication unless extensively edited.
Ok!
Sincerely regards
Marcelo F Cassini.