Author's response to reviews

Title: Preoperative diagnosis and successful surgery of strangulated internal hernia through a defect in the falciform ligament: Report of a Case

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Author’s response to reviews: see over
April 11, 2012

Dear Biomed Central Editorial Team,

MS: 1168593676646038 – “Preoperative diagnosis and successful surgery of strangulated internal hernia through a defect in the falciform ligament: Report of a Case.”

Thank you for consideration of our manuscript for publication in your journal. We have reviewed the manuscript and made changes according to your reviewer’s comments, which we have detailed below.

Reviewer (Dr Julie Wesp)
MINOR COMMENTS:
1. It is implied but not said specifically that this patient was considered to have had an acute abdomen which required immediate surgical intervention. Is this true?
   • Yes, this is true. We have clarified the physical exam findings to make this more clear (see answer below).

If so, would it be then be helpful to mention the role of physical examination in recognizing an acute abdomen; and how physical examination aids in the decision to take a patient to the operating room, in combination with the findings on CT?
   • Per your suggestion, we added all the clinical information that was available to address this comment on page 4. We added the following sentence: “Subsequent serial physical examinations of the abdomen revealed signs of continuing, severe abdominal pain with patient grimacing, though without significant rigidity or guarding. Full characterization of pain was limited by the patient’s low level of consciousness due to past cerebrovascular accident. In addition to abdominal pain, the patient continued to have decreased urine output despite aggressive hydration, leading examining physicians to search for possibly severe, occult abdominal pathology.”

2. Additionally, there is no mention of a working diagnosis. Please provide possible other causes of the patient’s condition other than underlying lung pathology. What, other than an internal hernia could have caused her abdominal
symptoms? This is important to mention so that the reader can understand the thought process of the practitioners involved in the patient's plan of care.

- Per your suggestion, we have clarified the differential diagnosis as follows: “The differential diagnosis included ulcer, GI tumor, angiodysplasia and diverticulitis of the small intestine, enteroaortic fistula associated with dissection or aneurysm, and small bowel ischemia with necrosis. However, no GI bleeding or evidence of ulcer was detected on emergent gastroendoscopy. A primary pulmonary source was also considered and chest X-ray revealed a 40mm mass in the inferior lobe of the right lung; the patient's symptoms were initially ascribed to swallowed and regurgitated blood from lung tumour-associated hemoptysis.”

3. This case is not worth reporting at this time. Perhaps with the addition of changes made after peer review, the case would be eligible for repeat submission and reevaluation. There is nothing reported in this case that ultimately changes the current standard of care. There is educational value in discussing findings of herniation through a defect in the falciform ligament and its rarity; however, the therapeutic treatment remains the same whether or not this phenomenon is recognized on CT examination. Patients with a defect in the falciform ligament who also have internal herniation will present with abdominal symptoms and will eventually be taken to the OR with an acute abdomen or with an unresolved bowel obstruction.

- Per your suggestions from comments 1 and 2, we have de-emphasized the CT findings themselves. While we believe their description may prove useful to future clinicians, we have now put these findings into the context of the physical exam and differential diagnosis of unremitting abdominal pain in a severely ill patient in whom initial investigation was unrevealing (normal EGD) or misleading (pulmonary mass).

4. Additionally, the case report should perhaps be reframed in that the comment should not be on reporting unique CT findings, but on creating a new thought process for differential diagnosis when a patient presents with abdominal symptoms and signs of obstruction. This differential diagnosis should be inclusive of the possibility of herniation through a defect in the falciform ligament. Then CT can be used to further support the suspected diagnosis.

- We agree with your comment. In addition to the changes outlines in comments 1-3, we have also added the following sentence to better justify the final move to OR (especially given the lack of “red flag” physical exam due to the patient’s poor mentation) on page
5: “In addition to ascites. CT demonstrated strangulated intestine with decreased contrast enhancement. We suspected necrosis of the strangulated intestines through the falciform ligament defect. The patient was therefore taken to the operating room emergently.”