Author's response to reviews

Title: Single Incision Laparoscopic Total Extraperitoneal Repair for Grynfeltt Hernia: a case report

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Version: 2 Date: 22 October 2013

Author's response to reviews: see over
Responses to the editor’s comments:

Dear Editor:
Thank you for your letter dated September 23, 2013. We are pleased to know that our manuscript was rated as potentially acceptable for publication in Journal of Medical Case Reports, subject to adequate revision and response to the comments raised by the reviewers.

Based on the instructions provided in your letter, we uploaded the file of the revised manuscript.

As you notice, we have revised the manuscript by modifying and formatting the whole article (formatted site marked in red colors), based on the comments made by the reviewers. Accordingly, we have uploaded a copy of the original manuscript with all the changes marked during the revision process.

Appended to this letter is our point-by-point response to the comments raised by the reviewers. As you notice, we agreed with all the comments. We would like to take this opportunity to express our sincere thanks to the reviewers who identified areas of our manuscript that needed corrections or modification. We would like also to thank you for allowing us to resubmit a revised copy of the manuscript.

I hope that the revised manuscript is acceptable for publication in Journal of Medical Case Reports.

Sincerely Yours,

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Responses to the reviewer’s comments (Reviewer Leonardo Solaini):
Dear Reviewer:
Your constructive criticism is greatly appreciated. We have made the following responses to comply with your honorable suggestions. (Note: The revised parts of the manuscript in response to the Reviewer’s comments have been marked in blue color)

Responses to major comments:

Comment 1:
This is a well presented and interesting report on the repair of Grynfelt hernia with a single incision laparoscopic approach. The technique suggested by the authors is definitely unique. Nevertheless, a 3x3cm defect might have been a suitable indication for an open approach without significant differences in the length of the incision. This would have been cheaper and possibly faster. Maybe the authors could point out which indications according to literature might be more suitable with the suggested approach.

Response 1:
Thank you for the constructive and insightful comments. Actually, initial physical examinations showed a 10 cm x 6 cm reducible soft mass at the left lower flank area. The definite size and location of fascial defect could not be precisely estimated before the surgery, in spite of the help of computed tomography. Thus, we used the minimally invasive technique to do the repair, avoiding the big incision. Although there are many management strategies for lumbar hernia, including open repair, intra-peritoneal laparoscopy and extra-peritoneal laparoscopy, no standard procedure for lumbar hernia repair has been proposed. We need more experiences to build the precise indications for different approaches.

Comment 2:
In the introduction section line 7 “minimal invasive surgery” should be “minimally invasive surgery”.

Response 2:
Thank you for your keen observation. We have made the corrections.

Thank you very much for your constructive and insightful comments!
Responses to the reviewer’s comments (Reviewer Haghi Mazeh):

Dear Reviewer:
Your constructive criticism is greatly appreciated. We have made the following responses to comply with your honorable suggestions.

Comment 1:
Although the report is well-written I do not see the added value of reporting another extraperitoneal repair of a lumbar hernia. The fact that a single port was used does not qualify to make this a report that contributes new data to what we already know. In my opinion, in this scenario the single port does not carry any advantage or true novelty over already reported laparoscopic repair.

Response 1:
Thank you for the constructive comment. In fact, single-port surgery provides a new concept for laparoscopic hernia repair, regardless of intra-peritoneal or extra-peritoneal technique. Through the small single incision, we performed adequate hernia repair. Compared with the conventional laparoscopic repair, wound pain would be reduced together with a better cosmetic result. Not only was the physical problem solved, but the psychological impact might also be ameliorated. The new approach to lumbar hernia repair, therefore, may be a feasible and safe option.

Thank you very much for your professional comments and suggestions!
Responses to the reviewer’s comments (Reviewer ABDULZAHRA HUSSAIN):

Dear Reviewer:

Your constructive criticism is greatly appreciated. We have made the following responses to comply with your honorable suggestions. (Note: The revised parts of the manuscript in response to Reviewer’s comments have been marked in green color)

Responses to major comments:

Comment 1:
Laparoscopic repair of lumbar hernia is first reported by Heniford group from USA in 1997 Laparoscopic Inferior and Superior Lumbar Hernia Repair B. Todd Heniford, MD; David A. Iannitti, MD; Michel Gagner, MD Arch Surg. 1997;132(10):1141-1144. doi:10.1001/archsurg.1997.01430340095017].

Heniford reported TAPP method of repair. This technique should also be highlighted in the discussion and authors need to compare the differences to give the reader full scope of management options.

Response 1:
Thank you for the constructive comments. We have added the difference between open method and laparoscopic approach for lumbar hernia repair. (Page 7, Line 3-8)

Comment 2:
Minimal access approach, of course is better than traditional big incision with its complications of pain, infection, seroma, recurrence and long recovery.

Response 2:
Thank you for the encouraging comments advocating the minimal access approach to hernia repair.

Comment 3:
The authors need to explain why they choose this position, location of trocars and the site of incision.

Response 3:
Thank you for the important comment. In our case, right decubitus position is adopted because of the protruding mass. The reason for making the incision over the left anterior axillary line between the twelfth rib and iliac crest was to facilitate instrumental manipulation for the management of the prolapsed mass and also for hernia repair. (Page 7, Line 14-17)
Comment 4:
The authors also should explain why they kept the patient for 4 days which is long hospitalization following laparoscopic surgery.

Response 4:
Thank you for the constructive comment. Due to the poor self-care ability and the patient’s intolerance to wound pain, the hospital stay was longer than the average (1 - 2 days after surgery). (Page 7, Line 17-18)

Comment 5:
We are doing abdominal hernia (including lumber one) as a day surgery case using TAPP technique which provide advantage of diagnostic laparoscopy. The TAPP technique can be performed using one 10mm port for introduction of the mesh and two 5mms ports for working instruments. which mean total incisions length is 20mms.

Response 5:
Thank you for the meaningful information. Due to the fact that it was our first case of single-incision laparoscopic total extraperitoneal repair for Grynfeltt hernia, the operation takes longer than usual.

Comment 6:
The inherent weakness of reporting hernia case is the follow up. The longest the follow up the higher the recurrence.6 months is short follow up.

Response 6:
Thank you for the constructive suggestions. The patient returned to the clinic 18 months later without evidence of recurrence. We have changed the follow-up time. (Page 5, Line 5-6)

Thank you very much for your professional comments and suggestions!