Author’s response to reviews

Title: Severe colonic bleeding in ulcerative colitis is refractory to selective transcatheater arterial embolization

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Jiing-Chyuan Luo, M.D.

BMC Gastroenterology

Dear Dr.

Thank you very much for your letter and the comments of the reviewers about our manuscript entitled “Severe colonic bleeding in ulcerative colitis is refractory to selective transcatheater arterial embolization”, by Jose Miranda-Bautista; Lucía Diéguez; Gracia Rodríguez-Rosales; Ignacio Marín-Jiménez; and myself (BMGE-D-18-00694). Please find enclosed the revised manuscript according to your comments and the replies to the points kindly raised by the Board of Editors and Reviewers, I hope that this version is now acceptable for publication in BMC Gastroenterology.

Yours sincerely,

Luis Menchén, MD, PhD.

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RESPONSES TO THE REVIEWERS´ COMMENTS

We are very grateful to the Board of Editors and Reviewers for their positive and helpful comments. Here follow the changes made in this new version:

Editor’s comments:

1. Corrected as suggested. Discussion section. Page 8, lines 14-25, page 9, lines 1-4

Reviewer #1:

1. Yes, we evaluated the presence of CMV in rectal biopsies before initiating adalimumab, and colectomy specimen evaluation ruled out CMV infection. Corrected as suggested. Case report #2, page 8, line 8.

2a. Oral mesalazine 4 gr per day, and rectal mesalazine 1 gr per day. Corrected as suggested. Case report #3, page 7, lines 8 and 9.

2b. Yes. After initiation of mesalazine the patient presented partial improvement, so corticosteroids were delayed. Severe haemorrhage presented acutely, and embolization was performed in the next 16 hours from the beginning of symptoms. Corrected as suggested. Case report 3#, page 7, line 16.


Reviewer #2:

First comment: All 3 patients showed partial improvement of clinical activity after initiation of their treatments (infliximab, adalimumab and mesalazine, respectively), but recurred thereafter. During the first 3-7 days, in which we evaluate the need of escalating therapy (including surgery), massive bleeding appeared so medical treatment could not be implemented. Case report #1, page 4, lines 20-21. Case report #2, page 6, lines 1-2. Case report #3, page 7, line 7.

Major issues:
1. Added as suggested. Case report #1, page 4, line 21. Case report #2, page 5, lines 23-24. Colectomy in Case report #3 was performed the same day of steroid treatment beginning.


3. Added as suggested. Patients #1 and #2, already diagnosed with UC, received enoxaparin 40 mg per day till beginning of the massive bleeding (page 4, line 11; and page 5, line 18. Patient #3, in whom UC was not diagnosed at admittance, did not received heparin.

4. Patient #1 had a poor and incomplete response after 3 days of intravenous corticosteroids: persistent bloody diarrhoea (10 stools per day), and high CRP levels in blood tests (10 mg/dL), with some amelioration of rectal symptoms and abdominal pain. That was the reason of initiation of infliximab. Added as suggested, page 4, lines 21-23.

5. In our case reports #2 and #3 diagnosis of site of bleeding was radiologic: CT scan and angiography localized bleeding. Page 6, line 4; and page 7, lines 9-10.

6. At the moment of bleeding some issues made us choose interventional radiology over endoscopic treatment: the severity of bleeding, the convenience of bowel cleansing before colonoscopy and the thought that the blood loading the large bowel would hamper the visualization of bleeding site and its treatment. But the issue is very interesting and we have included it in the discussion. Discussion, page 9, lines 19-25.

7. Added as suggested. Reference number .

Minor issues:

1. English language has been revised throughout the entire manuscript. Corrected as suggested. Introduction, page 3, line 6.


