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REVIEWER'S REPORT

Manuscript No.: IJAR-57830

Title: Acute Colonic Pseudo-obstruction (Ogilvie Syndrome) after Total Hip Arthroplasty: A Case Report,

Recommendation:
Accept after minor revision

Rating	Excel.	Good	Fair	Poor
Originality		✔,		
Techn. Quality		✔,		
Clarity	✔,			
Significance	✔,			

Reviewer Name: Dr. Bilqees Hamza

Detailed Reviewer's Report

The manuscript titled **"Acute Colonic Pseudo-obstruction (Ogilvie Syndrome) after Total Hip Arthroplasty: A Case Report"** highlights a rare but severe gastrointestinal complication within major orthopedic surgery. The scope of this study focuses on the clinical presentation of acute colonic pseudo-obstruction (ACPO), or Ogilvie syndrome, which is characterized by significant colonic dilatation without any mechanical blockage.

The paper evaluates the post-surgical timeline of a 59-year-old male patient who developed intestinal obstruction symptoms just two days after a total hip arthroplasty. Because delayed diagnosis can quickly lead to life-threatening issues like colonic ischemia or cecal perforation, this case report emphasizes the critical need for early medical recognition and a high index of clinical suspicion when managing postoperative patients.

The study provides a detailed account of a patient with an 8-year history of hypertension who experienced a complete cessation of stool and flatus, vomiting, and lower gastrointestinal bleeding shortly after his hip surgery. The primary diagnostic dilemma arose from a preoperative abdominopelvic computed tomography (CT) scan. The imaging suggested a true mechanical large-bowel obstruction caused by an apparent rectal wall thickening, which mistakenly pointed toward an obstructive tumor or lesion.

This radiologic ambiguity led the surgical team to perform an exploratory laparotomy through a midline incision. The true nature of the condition was discovered intraoperatively. Surgeons found diffuse

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dilatation of the small bowel (~4 cm) and massive cecal distension (~10 cm), but absolutely no mechanical obstacle or physical blockage. This key finding confirmed that the structural abnormalities seen on the CT scan were misleading, establishing a definitive diagnosis of Ogilvie syndrome.

The manuscript explores the underlying pathophysiology of ACPO, noting it is driven by autonomic dysregulation of colonic motility, specifically involving sympathetic overactivity, parasympathetic dysfunction, or a combination of both. The author outlines a clear, stepwise approach to managing the condition, which typically begins with conservative measures such as bowel rest, nasogastric or rectal decompression, and correcting fluid or electrolyte imbalances. It also notes that pharmacologic options like neostigmine or colonoscopic decompression can be used before turning to surgery.

The main scholarly contribution of this report is its detailed analysis of the diagnostic pitfalls linked to postoperative imaging. It serves as a reminder that radiographic findings can mimic physical obstructions, sometimes leading to unnecessary major surgeries. In this specific case, once the abdomen was open, the team successfully resolved the issue by performing a decompressive cecostomy, which led to an excellent recovery and a favorable outcome for the patient.

Suggestions for Improvement

- **Incorporate a Visual Stepwise Management Algorithm Flowchart:** Add a clear management algorithm flowchart to guide clinicians through a stepwise approach. The flowchart should show the transition from initial conservative therapies (bowel rest, fluid correction, medication changes) to pharmacologic choices (neostigmine), colonoscopic decompression, and finally to surgery when there is diagnostic uncertainty or suspected perforation.
- **Introduce a Summary Matrix of Postoperative Risk Factors:** Include a structured table that summarizes the common predisposing factors and clinical risks linked to Ogilvie syndrome, such as advanced age, male sex, specific medication exposures, metabolic imbalances, and recent major lower extremity arthroplasties.
- **Reorganize Text with Standard Academic Subheadings:** Break up the continuous narrative sections within the **"Case Presentation"** and **"Discussion"** segments. Use clear, professional subheadings such as **"Initial Postoperative Symptoms," "Radiological Evaluation and Misinterpretation," "Intraoperative Findings,"** and **"Pathophysiological Mechanisms of Autonomic Dysregulation"**.
- **Expand the Pathophysiology and Pharmacology Discussion:** Provide a deeper explanation of the autonomic nervous system's role in colonic motility. Elaborate on how sympathetic

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overactivity or parasympathetic inhibition stops bowel movement, and explain the mechanism of action of neostigmine as an acetylcholinesterase inhibitor used to restore balance.

- **Provide Detailed Histopathological or Visual Explanations:** Clarify why the CT scan erroneously showed rectal wall thickening. Explain whether this was due to localized fecal impaction, artifact from pelvic position, or localized fluid collection, helping readers understand how to avoid similar diagnostic mistakes.
- **Detail Post-Cecostomy Care and Long-Term Follow-Up:** Expand the clinical case description to explain the post-operative care following the decompressive cecostomy. Include information on how long the tube remained in place, when normal bowel function returned, and the patient's long-term recovery status.
- **Refine Figure Captions with Specific Clinical Details:** Update the captions for Figure 1 and Figure 2 to include precise clinical measurements from the surgery, such as the 10 cm cecal distension and the 4 cm small bowel measurement.
- **Standardize In-Text Citation Formats:** Review and correct all in-text citations to ensure they consistently follow a standard style manual (like AMA or Vancouver). Avoid placing raw editorial placeholders or mixed numbers directly into the narrative sentences.
- **Complete Missing Metadata in the Reference Bibliography:** Check the reference list to ensure all entries are complete and consistently formatted. Verify that entries include complete journal titles, volume numbers, issue numbers, precise page ranges, and working Digital Object Identifiers (DOIs) where available.

Recommendation for Publication

I recommend this manuscript for **publication with minor revision**. The case report highlights a critical, time-sensitive diagnostic challenge that general surgeons and orthopedic teams frequently face during major joint replacements. The clinical narrative is clear, and the accompanying CT and intraoperative images provide excellent support for the final diagnosis. Once the author adds a visual treatment algorithm, includes a structured table of risk factors, and updates the text with professional subheadings, this paper will be a valuable, high-impact addition to clinical literature focused on perioperative safety and post-surgical complications.