BUKTI KORESPONDENSI

Judul Artikel : Atraumatic acute compartment syndrome in anticoagulated patient: A case report

Jurnal : Annals of Medicine and Surgery

Author : Dara Ninggar Ghassani, Denny Suwanto, Meity Ardiana

Corresponding: Meity Ardiana

No.	Perihal	Tanggal	Komentar Editor Jurnal	Komentar Penulis
1	Pengiriman Artikel	27 Juni 2022 30 Juni 2022 2-16 Juli 2022	Editor mengirim pesan otomatis bahwa jurnal telah disubmit. **Email :** 27 Juni 2022 pukul 11.08 Memerlukan approval Penulis. **Email :** 30 Juni 2022 pukul 11.09 Naskah ditangani oleh Asisten Pelaksana dan Editor Eksekutif Maliha Agha. Email : 2 Juli 2022 pukul 21.08 Naskah sedang under review. Email : 14 Juli 2022 pukul 04.04 Status kiriman naskah kini telah berkembang menjadi: 'Peninjauan yang diperlukan selesai'. **Email :** 16 Juli 2022 pukul 22.17	-
2	Pengiriman Revisi	21 Juli 2022	Para pengulas telah mengomentari makalah Anda di atas. Mereka menyatakan bahwa naskah tersebut tidak dapat	Penulis mengirim revisi melalui dashboard

			diterima untuk diterbitkan dalam bentuk yang sekarang.Memerlukan perbaikan. **Email :** 21 Juli 2022 pukul 08.07	website, keterangan revisi: • Sejarah obat-obatan, informasi relevan terkait penyakit turunan pasien, dan rekam psikososial pasien. • Artikel harus mengikuti kriteria SCARE 2020 dan menyertakan keterangan tersebut di bagian metode. • Pembetulan pengejaan dan grammar. • Koreksi kalimat dalam informed consent. Terlampir artikel revisi highlight.
		3 Agustus 2022	Kami ingin mengingatkan Anda bahwa revisi artikel Anda akan jatuh tempo dalam 7 hari. Jika Anda merevisi karya tersebut, pastikan untuk menyertakan dalam naskah revisi tersebut daftar perubahan atau sanggahan terhadap setiap poin yang diajukan oleh pengulas. **Email :** 3 Agustus 2022 pukul 11.11 Revisi AMSU-D-22-01249 diharapkan paling lambat 10 Agustus 2022. Anda telah dikirimi 1 pemberitahuan pengingat. Yang	

			terakhir dikirim pada 03 Agustus 2022. **Email :** 12 Agustus 2022 pukul 11.10 Reminder pengiriman naskah revisi. **Email :** 14 Agustus 2022 pukul 01.51, 21 Agustus 2022 pukul 18.03	
			Pesan otomatis, naskah revisi telah diterima. **Email :** 23 Agustus 2022 pukul 20.28 Naskah ditangani oleh Asisten Pelaksana dan Editor Eksekutif Chief Riaz Agha.. **Email :** 25 Agustus 2022 pukul 18.10	
3	Penerimaan Artikel	28 Agustus 2022 1-2 September 2022	Naskah berjudul "Atraumatic Acute Compartment Syndrome In Anticoagulated Patient: A Casereport" telah diterima untuk dipublikasikan. **Email :** 28 Agustus 2022 pukul 04.35; 28 Agustus 2022 pukul 06.06	
4	Publikasi Artikel	7-19 September 2022	Editor mengirim Rights & Access form dan pembayaran APC. **Email :** 7 September 2022 pukul 07.03; 9 September 2022 pukul 07.02 Pengiriman proof corections. **Email :** 9 September 2022 pukul	Penulis telah mengisi dan koreksi Rights & Access form dan galley proof melalui website jurnal.

			07.03; 12 September 2022 pukul 23.11 Email konfirmasi pengiriman Rights & Access form. **Email :** 15 September 2022 pukul 22.27. Koreksi proof diterima. **Email :** 19 September 2022 pukul 22.04	

ardiana, Meity <meityardiana@fk.unair.ac.id>

Submission to Annals of Medicine and Surgery requires action

1 pesan

Annals of Medicine and Surgery <em@editorialmanager.com> 27 Juni 2022 pukul 11.08
Balas Ke: Annals of Medicine and Surgery <annalsjournal@elsevier.com>
Kepada: Meity Ardiana <meityardiana@fk.unair.ac.id>

This is an automated message.

ATRAUMATIC ACUTE COMPARTMENT SYNDROME IN ANTICOAGULATED PATIENT: A CASE REPORT

Dear Dr Ardiana,

We would like to remind you that further action is required to complete the above referenced submission.

You have received this message for one of two reasons. Either: (a) your manuscript has been transferred from another journal and you must now complete your resubmission, or (b) technical comments (included below) need to be addressed before resubmitting your manuscript.

When you are ready to proceed with your submission, please log in as an author at https://www.editorialmanager.com/AMSU/ and navigate to the "Submissions Sent Back to Author" folder. There you can edit your submission by clicking "Edit submission" under the "Action Link" menu.

Thank you for considering this journal, and we look forward to receiving your submission.

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PDF for submission to Annals of Medicine and Surgery requires approval

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This is an automated message.

ATRAUMATIC ACUTE COMPARTMENT SYNDROME IN ANTICOAGULATED PATIENT: A CASE REPORT

Dear Dr Ardiana,

We would like to remind you that the PDF for your above referenced submission has been built and required your approval. If you have already approved the PDF, this e-mail can be ignored.

Please review the PDF carefully, before approving it, to confirm it appears as you expect and is free of any errors. Once approved, no further changes can be made.

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* Log into Editorial Manager as an author at: https://www.editorialmanager.com/AMSU/.
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Editor handles AMSU-D-22-01249

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Annals of Medicine and Surgery <em@editorialmanager.com> 2 Juli 2022 pukul 21.07
Balas Ke: Annals of Medicine and Surgery <annalsjournal@elsevier.com>
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Ms. Ref. No.: AMSU-D-22-01249
Title: ATRAUMATIC ACUTE COMPARTMENT SYNDROME IN ANTICOAGULATED PATIENT: A CASE REPORT
Annals of Medicine and Surgery

Dear Dr Ardiana,

Your submission "ATRAUMATIC ACUTE COMPARTMENT SYNDROME IN ANTICOAGULATED PATIENT: A CASE REPORT" will be handled by Editor in Chief Riaz Agha.

You may check on the progress of your paper by logging on to the Editorial Manager as an author.

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Annals of Medicine and Surgery

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Annals of Medicine and Surgery

Dear Dr Ardiana,

Your submission "ATRAUMATIC ACUTE COMPARTMENT SYNDROME IN ANTICOAGULATED PATIENT: A CASE REPORT" will be handled by Assistant Managing and Executive Editor Maliha Agha.
[Kutipan teks disembunyikan]

ardiana, Meity <meityardiana@fk.unair.ac.id>

Track the status of your submission to Annals of Medicine and Surgery

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Track your Elsevier submission <no-reply@submissions.elsevier.com> 14 Juli 2022 pukul 04.04
Kepada: meityardiana@fk.unair.ac.id

Manuscript Number: AMSU-D-22-01249
Manuscript Title: ATRAUMATIC ACUTE COMPARTMENT SYNDROME IN ANTICOAGULATED PATIENT: A CASE REPORT
Journal: Annals of Medicine and Surgery

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Your submitted manuscript is currently under review. The peer review process can take a while, so we are trying out a new service that allows you to track the peer review status of your submission in more detail. You can access the service here:
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Balas Ke: Annals of Medicine and Surgery <annalsjournal@elsevier.com>
Kepada: Meity Ardiana <meityardiana@fk.unair.ac.id>

Journal: Annals of Medicine and Surgery
Ref: AMSU-D-22-01249
Title: ATRAUMATIC ACUTE COMPARTMENT SYNDROME IN ANTICOAGULATED PATIENT: A CASE REPORT

Dear Dr Ardiana

I am pleased to inform you that the status of your submission has now progressed to: 'Required reviews complete'.

This status means that I have received the minimum number of required reviews, which I will now evaluate in order to make a decision on your paper.

If the current reviews conflict with one another or are not detailed enough, I may need to seek the opinion of another reviewer to make a fair and informed conclusion about your paper. For this reason the status of your paper may change back to 'under review' for a short period of time.

As soon as the final editor's decision can be made, you will be notified via email.

I appreciate your understanding of the time required to provide you with a thorough decision and comments on your submission.

Kind regards,

Annals of Medicine and Surgery

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Balas Ke: Annals of Medicine and Surgery <annalsjournal@elsevier.com>
Kepada: Meity Ardiana <meityardiana@fk.unair.ac.id>

Ms. Ref. No.: AMSU-D-22-01249
Title: ATRAUMATIC ACUTE COMPARTMENT SYNDROME IN ANTICOAGULATED PATIENT: A CASE REPORT
Annals of Medicine and Surgery

Dear Dr Ardiana,

The reviewers have commented on your above paper. They indicated that it is not acceptable for publication in its present form.

However, if you feel that you can suitably address the Managing Editor (if applicable) and Reviewer(s) comments (included below), I invite you to revise and resubmit your manuscript.

Please carefully address the issues raised in the comments.

If you are submitting a revised manuscript, please also:

a) outline each change made (point by point) as raised in the reviewer comments

AND/OR

b) provide a suitable rebuttal to each reviewer comment not addressed

c) Supply a revised manuscript with track changes - Your revised manuscript with track changes added or your revisions highlighted in bold/red.

d) Supply a revised manuscript un-tracked - A clean unmarked copy of your revised manuscript.

To submit your revision, please do the following:

1. Go to: https://www.editorialmanager.com/amsu/

2. Enter your login details

3. Click [Author Login]
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4. Click [Submissions Needing Revision]

I look forward to receiving your revised manuscript.

Yours sincerely,

Dr Riaz Agha
Editor-in-Chief
Annals of Medicine and Surgery

Reviewer(s) comments:

Managing Editor

Please can you make the following changes/checks:

1. Please ensure your case report is compliant with the SCARE Guidelines 2020: http://www.scareguideline.com and submit a completed SCARE 2020 checklist.

Please pay particular attention to the following criteria which are often missed:
- Who performed the procedure? (item 9d)
- patient perspective (item 12)

- Drug history, family history including any relevant genetic information, and psychosocial history (item 5d)
- Where relevant - intervention adherence and tolerability (item 10c)
- Post-intervention considerations (item 9f)

2. Please also ensure you state that the work has been reported in line with the SCARE 2020 criteria:

Agha RA, Franchi T, Sohrabi C, Mathew G, for the SCARE Group. The SCARE 2020 Guideline: Updating Consensus Surgical CAse REport (SCARE) Guidelines, International Journal of Surgery 2020;84:226-230.

3. Please cite the SCARE 2020 paper above in your text in the methods section and the add the reference to your references section.

4. Please ensure you submit a structured abstract with sub-headings as follows:
Introduction and importance, Case presentation, clinical Discussion, Conclusion

5. Can you also please ensure you go through the entire manuscript and check the spelling, grammar and syntax and ensure the language is concise. If you need our author support services, you can access them here:
https://www.ijspg.com/services/author-support

6. Please be very clear about what this adds to the existing literature and clearly detail learning points.

7. Please ensure you submit your work with a Research Registry unique identifying number (UIN) if its first in man i.e. the first time a new device or surgical technique is performed: www.researchregistry.com – it can't progress without being registered. Please ensure you also state your registration UIN in your methods section and reference it including a hyperlink to it if registration is appropriate.

8. If you haven't already, please include your "highlights" which are 3-5 bullet points summarising the novel aspects and/or learning points (maximum 85 characters, including spaces, per bullet point).

9. The consent statement in the author form is not suitable. We need a statement like this:

Written informed consent was obtained from the patient for publication of this case report and accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal on request.

Please see consent section in instructions to authors for further information.

10. Please ensure any images/figures/photos are suitably anonymised with no patient information or means of identifying the patient.

11. Please add a Guarantor on the Author form, if you haven't already.
The guarantor is that individual who accepts full responsibility for the work and/or the conduct of the study, had access to the data, and controlled the decision to publish.

12. Please add the following statement above references:

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Not commissioned, externally peer-reviewed

13. Above references, please state the following headings with your response (if something doesn't apply, say N/a or none or none declared):
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- sources of funding
- ethical approval
- consent
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ardiana, Meity <meityardiana@fk.unair.ac.id> 12 Agustus 2022 pukul 16.04
Kepada: daraghassani@gmail.com

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Author revision reminder

1 pesan

Annals of Medicine and Surgery <em@editorialmanager.com> 3 Agustus 2022 pukul 11.11
Balas Ke: Annals of Medicine and Surgery <annalsjournal@elsevier.com>
Kepada: Meity Ardiana <meityardiana@fk.unair.ac.id>

Ms. Ref. No.: AMSU-D-22-01249
Title: ATRAUMATIC ACUTE COMPARTMENT SYNDROME IN ANTICOAGULATED PATIENT: A CASE REPORT
Annals of Medicine and Surgery

Dear Dr Ardiana,

We would like to remind you that a revision of your article: ATRAUMATIC ACUTE COMPARTMENT SYNDROME IN ANTICOAGULATED PATIENT: A CASE REPORT is due in 7 days

If you are revising the work, please be sure to include with the revised manuscript a list of changes or a rebuttal to each point raised by the reviewers.

To submit your revised manuscript, go to https://www.editorialmanager.com/AMSU/ and log in as an author:

On the main menu page, click on "Submissions Needing Revision" to find your submission record.

We look forward to hearing from you. If you have any questions, please do not hesitate to contact the journal.

Kind regards

Annals of Medicine and Surgery

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ardiana, Meity <meityardiana@fk.unair.ac.id>

Your Submission

2 pesan

Annals of Medicine and Surgery <em@editorialmanager.com> 21 Juli 2022 pukul 08.07
Balas Ke: Annals of Medicine and Surgery <annalsjournal@elsevier.com>
Kepada: Meity Ardiana <meityardiana@fk.unair.ac.id>

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However, if you feel that you can suitably address the Managing Editor (if applicable) and Reviewer(s) comments (included below), I invite you to revise and resubmit your manuscript.

Please carefully address the issues raised in the comments.

If you are submitting a revised manuscript, please also:

a) outline each change made (point by point) as raised in the reviewer comments

AND/OR

b) provide a suitable rebuttal to each reviewer comment not addressed

c) Supply a revised manuscript with track changes - Your revised manuscript with track changes added or your revisions highlighted in bold/red.

d) Supply a revised manuscript un-tracked - A clean unmarked copy of your revised manuscript.

To submit your revision, please do the following:

1. Go to: https://www.editorialmanager.com/amsu/

2. Enter your login details

3. Click [Author Login]
This takes you to the Author Main Menu.

4. Click [Submissions Needing Revision]

I look forward to receiving your revised manuscript.

Yours sincerely,

Dr Riaz Agha
Editor-in-Chief
Annals of Medicine and Surgery

Reviewer(s) comments:

Managing Editor

Please can you make the following changes/checks:

1. Please ensure your case report is compliant with the SCARE Guidelines 2020: http://www.scareguideline.com and submit a completed SCARE 2020 checklist.

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- patient perspective (item 12)

- Drug history, family history including any relevant genetic information, and psychosocial history (item 5d)
- Where relevant - intervention adherence and tolerability (item 10c)
- Post-intervention considerations (item 9f)

2. Please also ensure you state that the work has been reported in line with the SCARE 2020 criteria:

Agha RA, Franchi T, Sohrabi C, Mathew G, for the SCARE Group. The SCARE 2020 Guideline: Updating Consensus Surgical CAse REport (SCARE) Guidelines, International Journal of Surgery 2020;84:226-230.

3. Please cite the SCARE 2020 paper above in your text in the methods section and the add the reference to your references section.

4. Please ensure you submit a structured abstract with sub-headings as follows:
Introduction and importance, Case presentation, clinical Discussion, Conclusion

5. Can you also please ensure you go through the entire manuscript and check the spelling, grammar and syntax and ensure the language is concise. If you need our author support services, you can access them here:
https://www.ijspg.com/services/author-support

6. Please be very clear about what this adds to the existing literature and clearly detail learning points.

7. Please ensure you submit your work with a Research Registry unique identifying number (UIN) if its first in man i.e. the first time a new device or surgical technique is performed: www.researchregistry.com – it can't progress without being registered. Please ensure you also state your registration UIN in your methods section and reference it including a hyperlink to it if registration is appropriate.

8. If you haven't already, please include your "highlights" which are 3-5 bullet points summarising the novel aspects and/or learning points (maximum 85 characters, including spaces, per bullet point).

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Written informed consent was obtained from the patient for publication of this case report and accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal on request.

Please see consent section in instructions to authors for further information.

10. Please ensure any images/figures/photos are suitably anonymised with no patient information or means of identifying the patient.

11. Please add a Guarantor on the Author form, if you haven't already.
The guarantor is that individual who accepts full responsibility for the work and/or the conduct of the study, had access to the data, and controlled the decision to publish.

12. Please add the following statement above references:

Provenance and peer review
Not commissioned, externally peer-reviewed

13. Above references, please state the following headings with your response (if something doesn't apply, say N/a or none or none declared):
- conflicts of interest
- sources of funding
- ethical approval
- consent
- author contribution
- research registration (for case reports detailing a new surgical technique or new equipment/technology)
- Guarantor

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Please ensure that you have completed and uploaded the correct author form for IJS Case Reports: https://www.elsevier.com/__data/promis_misc/2020_IJSCR_Author_Disclosure_Form.docx.
Please also make sure that you complete each section of the form.

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Reviewer #1: This case report may be accepted for the publication.

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For further assistance, please visit our customer support site at http://help.elsevier.com/app/answers/list/p/7923. Here you can search for solutions on a range of topics, find answers to frequently asked questions and learn more about EM via interactive tutorials. You will also find

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ardiana, Meity <meityardiana@fk.unair.ac.id> 12 Agustus 2022 pukul 16.04
Kepada: daraghassani@gmail.com

[Kutipan teks disembunyikan]

ardiana, Meity <meityardiana@fk.unair.ac.id>

Your revision is past due date

1 pesan

Annals of Medicine and Surgery <em@editorialmanager.com> 12 Agustus 2022 pukul 11.10
Balas Ke: Annals of Medicine and Surgery <annalsjournal@elsevier.com>
Kepada: Meity Ardiana <meityardiana@fk.unair.ac.id>

Ref.: Ms. No. AMSU-D-22-01249
ATRAUMATIC ACUTE COMPARTMENT SYNDROME IN ANTICOAGULATED PATIENT: A CASE REPORT
Annals of Medicine and Surgery

Dear Dr Ardiana,

The revision of AMSU-D-22-01249 was expected by Aug 10, 2022.

You have been sent 1 reminder notices. The last one was sent on Aug 03, 2022.

If you require more time, please contact the journal office. If you are ready to submit your revision, then please go to https://www.editorialmanager.com/AMSU/ and submit the revision.

username: mailto:meityardiana@fk.unair.ac.id
password: https://www.editorialmanager.com/amsu/l.asp?i=377761&l=XHBESW0Q

Kind regards,

Annals of Medicine and Surgery

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Author revision reminder

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We would like to remind you that a revision of your article: ATRAUMATIC ACUTE COMPARTMENT SYNDROME IN ANTICOAGULATED PATIENT: A CASE REPORT is due in 7 days

If you are revising the work, please be sure to include with the revised manuscript a list of changes or a rebuttal to each point raised by the reviewers.

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On the main menu page, click on "Submissions Needing Revision" to find your submission record.

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Kind regards

Annals of Medicine and Surgery

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ardiana, Meity <meityardiana@fk.unair.ac.id>

Your revision is past due date

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Annals of Medicine and Surgery <em@editorialmanager.com> 12 Agustus 2022 pukul 11.10
Balas Ke: Annals of Medicine and Surgery <annalsjournal@elsevier.com>
Kepada: Meity Ardiana <meityardiana@fk.unair.ac.id>

Ref.: Ms. No. AMSU-D-22-01249
ATRAUMATIC ACUTE COMPARTMENT SYNDROME IN ANTICOAGULATED PATIENT: A CASE REPORT
Annals of Medicine and Surgery

Dear Dr Ardiana,

The revision of AMSU-D-22-01249 was expected by Aug 10, 2022.

You have been sent 1 reminder notices. The last one was sent on Aug 03, 2022.

If you require more time, please contact the journal office. If you are ready to submit your revision, then please go to https://www.editorialmanager.com/AMSU/ and submit the revision.

username: mailto:meityardiana@fk.unair.ac.id
password: https://www.editorialmanager.com/amsu/l.asp?i=377761&l=XHBESW0Q

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Kepada: Meity Ardiana <meityardiana@fk.unair.ac.id>

Ms. Ref. No.: AMSU-D-22-01249
Title: ATRAUMATIC ACUTE COMPARTMENT SYNDROME IN ANTICOAGULATED PATIENT: A CASE REPORT
Annals of Medicine and Surgery

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We have now sent you eight or more reminders regarding the submission of your revised manuscript.

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Ms. Ref. No.: AMSU-D-22-01249
Title: ATRAUMATIC ACUTE COMPARTMENT SYNDROME IN ANTICOAGULATED PATIENT: A CASE REPORT
Annals of Medicine and Surgery

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We have now sent you eight or more reminders regarding the submission of your revised manuscript.

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Submission Confirmation for AMSU-D-22-01249R1

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Balas Ke: Annals of Medicine and Surgery <annalsjournal@elsevier.com>
Kepada: Meity Ardiana <meityardiana@fk.unair.ac.id>

Ms. Ref. No.: AMSU-D-22-01249R1
Title: ATRAUMATIC ACUTE COMPARTMENT SYNDROME IN ANTICOAGULATED PATIENT: A CASE REPORT
Annals of Medicine and Surgery

Dear Dr Ardiana,

This message is to acknowledge that we have received your revised manuscript for reconsideration for publication in Annals of Medicine and Surgery.

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Editor handles AMSU-D-22-01249R1

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Balas Ke: Annals of Medicine and Surgery <annalsjournal@elsevier.com>
Kepada: Meity Ardiana <meityardiana@fk.unair.ac.id>

Ms. Ref. No.: AMSU-D-22-01249R1
Title: ATRAUMATIC ACUTE COMPARTMENT SYNDROME IN ANTICOAGULATED PATIENT: A CASE REPORT
Annals of Medicine and Surgery

Dear Dr Ardiana,

Your submission "ATRAUMATIC ACUTE COMPARTMENT SYNDROME IN ANTICOAGULATED PATIENT: A CASE REPORT" will be handled by Editor in Chief Riaz Agha.

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Your Submission

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Ms. Ref. No.: AMSU-D-22-01249R1
Title: ATRAUMATIC ACUTE COMPARTMENT SYNDROME IN ANTICOAGULATED PATIENT: A CASE REPORT
Annals of Medicine and Surgery

Dear Dr Ardiana,

I am pleased to inform you that your paper "ATRAUMATIC ACUTE COMPARTMENT SYNDROME IN ANTICOAGULATED PATIENT: A CASE REPORT" has been accepted for publication in Annals of Medicine and Surgery.

This journal is fully open access; all articles will be immediately and permanently free for everyone to read and download. To provide Open Access, this journal has a publication fee which needs to be met by the authors or their research funders.
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Yours sincerely,

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Annals of Medicine and Surgery

Comments from the editors and reviewers:

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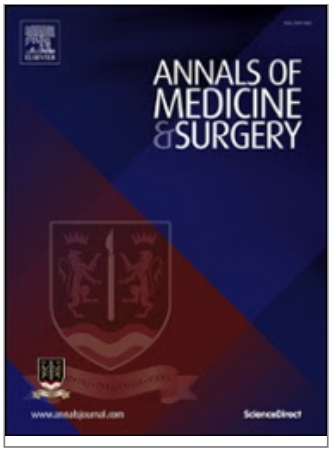

Your article *ATRAUMATIC ACUTE COMPARTMENT SYNDROME IN ANTICOAGULATED PATIENT: A CASE REPORT* will be published in Annals of Medicine and Surgery.

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Kepada: meityardiana@fk.unair.ac.id

Our reference: AMSU 104530
Article reference: AMSU_AMSU-D-22-01249
Article title: Atraumatic acute compartment syndrome in anticoagulated patient: A case report
To be published in: Annals of Medicine and Surgery

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Our reference: AMSU 104530
Article reference: AMSU_AMSU-D-22-01249
Article title: Atraumatic acute compartment syndrome in anticoagulated patient: A case report
To be published in: Annals of Medicine and Surgery

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A.Achuthan@elsevier.com <A.Achuthan@elsevier.com>
Kepada: meityardiana@fk.unair.ac.id

9 September 2022 pukul 07.03

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Our reference: AMSU 104530
Article reference: AMSU_AMSU-D-22-01249
Article title: Atraumatic acute compartment syndrome in anticoagulated patient: A case report
To be published in: Annals of Medicine and Surgery

Dear Dr Ardiana,

We recently sent you proofs of the above-mentioned article. Our records indicate that we have not yet received your proof corrections or your approval to publish the article without change.

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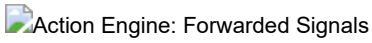
Balas Ke: r.narayanan@elsevier.com
Kepada: meityardiana@fk.unair.ac.id



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We look forward to your response!

Kind regards,
Rasana Narayanan
Journal Manager

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Days Overdue	**3**
Item Number	**AMSU_104530**
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A.Achuthan@elsevier.com <A.Achuthan@elsevier.com> 15 September 2022 pukul 22.27
Kepada: meityardiana@fk.unair.ac.id

Our reference: AMSU 104530
Article reference: AMSU_AMSU-D-22-01249
Article title: Atraumatic acute compartment syndrome in anticoagulated patient: A case report
To be published in: Annals of Medicine and Surgery

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ardiana, Meity <meityardiana@fk.unair.ac.id> 18 September 2022 pukul 21.21
Kepada: daraghassani@gmail.com

[Kutipan teks disembunyikan]

Corrections received - [AMSU_104530]

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optteam@elsevierproofcentral.com <optteam@elsevierproofcentral.com> 19 September 2022 pukul 22.04
Kepada: meityardiana@fk.unair.ac.id

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Author's Response To Reviewer Comments

Close

Author Response Letter

Reviewer(s) comments:

Managing Editor

Please can you make the following changes/checks:
1. Please ensure your case report is compliant with the SCARE Guidelines 2020: http://www.scareguideline.com and submit a completed SCARE 2020 checklist.
Please pay particular attention to the following criteria which are often missed:
- Who performed the procedure? (item 9d)
- patient perspective (item 12)
- Drug history, family history including any relevant genetic information, and psychosocial history (item 5d)
- Where relevant - intervention adherence and tolerability (item 10c)
- Post-intervention considerations (item 9f)
Response 1: We have added SCARE checklist in supplementary materials.

2. Please also ensure you state that the work has been reported in line with the SCARE 2020 criteria:
Agha RA, Franchi T, Sohrabi C, Mathew G, for the SCARE Group. The SCARE 2020 Guideline: Updating Consensus Surgical CAse REport (SCARE) Guidelines, International Journal of Surgery 2020;84:226-230.
Response 2: This case report has been reported in line with the SCARE Criteria.

3. Please cite the SCARE 2020 paper above in your text in the methods section and the add the reference to your references section.
Response 3: SCARE 2020 has been cited.

4. Please ensure you submit a structured abstract with sub-headings as follows:
Introduction and importance, Case presentation, clinical Discussion, Conclusion
Response 4: abstract has been written using those sub-headings.

5. Can you also please ensure you go through the entire manuscript and check the spelling, grammar and syntax and ensure the language is concise. If you need our author support services, you can access them here:
https://www.ijspg.com/services/author-support
Response 5: we have checked the spelling and grammar of the manuscript.

6. Please be very clear about what this adds to the existing literature and clearly detail learning points.
Response 6: learning points have been added after the conclusion.

7. Please ensure you submit your work with a Research Registry unique identifying number (UIN) if its first in man i.e. the first time a new device or surgical technique is performed: www.researchregistry.com – it can't progress without being registered. Please ensure you also state your registration UIN in your methods section and reference it including a hyperlink to it if registration is appropriate.
Response 7: This article is a case report. Hence, no research registration is needed.

8. If you haven't already, please include your "highlights" which are 3-5 bullet points summarising the novel aspects and/or learning points (maximum 85 characters, including spaces, per bullet point).
Response 8: We have added 4 learning points after the conclusion section.

9. The consent statement in the author form is not suitable. We need a statement like this:
Written informed consent was obtained from the patient for publication of this case report and accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal on request.
Please see consent section in instructions to authors for further information.
Response 9: We have added the consent statement as recommended.

10. Please ensure any images/figures/photos are suitably anonymised with no patient information or means of identifying the patient.
Response 10: We have used images/figures/photos that are suitably anonymised with no patient information.

11. Please add a Guarantor on the Author form, if you haven't already.
The guarantor is that individual who accepts full responsibility for the work and/or the conduct of the study, had access to the data, and controlled the decision to publish.
Response 11: Guarantors have been added.

12. Please add the following statement above references:
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Annals of Medicine and Surgery

ATRAUMATIC ACUTE COMPARTMENT SYNDROME IN ANTICOAGULATED PATIENT: A CASE REPORT

--Manuscript Draft--

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Article Type:	Case Report
Keywords:	atraumatic; acute compartment syndrome; systemic anticoagulation; case report
Corresponding Author:	Meity Ardiana Airlangga University Faculty of Medicine INDONESIA
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	Meity Ardiana
	Denny Suwanto
Manuscript Region of Origin:	INDONESIA
Abstract:	Introduction and importance Compartment syndrome is a well-known surgical emergency caused by increasing pressure inside the fascial or osteo fascial compartment, resulting in vascular compromise, ischemia, and necrosis.This condition usually occurs following a traumatic incident. Here we present a report of nontraumatic acute compartment syndrome caused by systemic anticoagulation in patients presenting with acute coronary syndrome. Case presentation We report a case of 51-year-old male with acute coronary syndrome receiving systemic anticoagulation which later developed significant swelling and tensing on his right arm. He also complained of pallor and paresthesia with decreased peripheral oxygen saturation on his right arm. Clinical discussion The patient was diagnosed with atraumatic acute compartment syndrome and he underwent fasciotomy promptly. His symptoms improved after undergoing faciotomy. Conclusions Atraumatic acute compartment syndrome is a rare case. Identifying this condition without typical history of underlying predisposition is important to avoid delaying emergent surgery as the key therapy.
Suggested Reviewers:	Dyana Sarvasti dyana_sarvasti@yahoo.com
	Anwar Santoso awscip@gmail.com
Response to Reviewers:	Author Response Letter Reviewer(s) comments: Managing Editor Please can you make the following changes/checks: 1. Please ensure your case report is compliant with the SCARE Guidelines 2020: http://www.scareguideline.com and submit a completed SCARE 2020 checklist.

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All authors contributed toward data analysis, drafting and revising the paper, gave final approval of the version to be published and agree to be accountable for all aspects of the work.

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Cover Letter

To:
Editor-in-Chief
Annals of Medicine and Surgery

May, 18th, 2022

Dear Dr. Riaz Agha

We wish to submit a case series entitled "**Atraumatic Acute Compartment Syndrome in Anticoagulated Patient: A Case Report**" by Dara Ninggar Ghassani, MD, Denny Suwanto, MD, Meity Ardiana, MD, for consideration for publication by Annals of Medicine and Surgery.

This manuscript is a case report of a spontaneous nontraumatic acute compartment syndrome in upper extremity in hospitalized patients with acute coronary syndrome settings receiving anticoagulation. Our aim was to raise awareness of the possibility of systemic anticoagulation as one of the possible cause in patients with compartment syndrome signs and symptoms, so that prompt treatment can be pursued in timely manner. We believe that this manuscript is appropriate for publication by Annals of Medicine and Surgery.

We declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this manuscript. This manuscript has not been published and is not under consideration for publication elsewhere.

On behalf of all the authors, I will act as guarantor and will correspond with the journal from this point onward. Please address all correspondence concerning this manuscript to me at meityardiana@fk.unair.ac.id

Thank you for your consideration of this manuscript.

Sincerely yours,
Meity Ardiana

Author Response Letter

Reviewer(s) comments:

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Response 8: We have added 4 learning points after the conclusion section.

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Please see consent section in instructions to authors for further information.

Response 9: We have added the consent statement as recommended.

10. Please ensure any images/figures/photos are suitably anonymised with no patient information or means of identifying the patient.

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Response: Thank you for your comment.

Highlight

- There are limited reports on the compartment syndrome of atraumatic origin
- Concurrent anticoagulation administration and all conditions that impairs blood coagulation may increase the risk of these hypothetical patophysiology
- Atraumatic acute compartment syndrome is a challenging diagnosis as the precipitating elements are not widely known
- These cases can very easily be neglected and prompt treatment could be delayed.

ATRAUMATIC ACUTE COMPARTMENT SYNDROME IN ANTICOAGULATED PATIENT: A CASE REPORT

Running title: Atraumatic Acute Compartment Syndrome

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Declaration of competing interest

The authors declare that they have no conflict of interest.

Acknowledgment

We would like to thank the Faculty of Medicine, Universitas Airlangga, Surabaya, Indonesia for providing support for our study and to all those who have helped this study until the completion of the manuscript.

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ATRAUMATIC ACUTE COMPARTMENT SYNDROME IN ANTICOAGULATED PATIENT: A CASE REPORT

Abstract

Introduction and importance: Compartment syndrome is a well-known surgical emergency caused by increasing pressure inside the fascial or osteo-fascial compartment, resulting in vascular compromise, ischemia, and necrosis. This condition usually occurs following a traumatic incident. Here we present a report of nontraumatic acute compartment syndrome caused by systemic anticoagulation in patients presenting with the acute coronary syndrome.

Case presentation: We report a case of a 51-year-old male with acute coronary syndrome receiving systemic anticoagulation, which later developed significant swelling and tensing on his right arm. He also complained of pallor and paresthesia with decreased peripheral oxygen saturation on his right arm.

Clinical discussion: The patient was diagnosed with atraumatic acute compartment syndrome and underwent fasciotomy promptly. His symptoms improved after undergoing fasciotomy.

Conclusions: Atraumatic acute compartment syndrome is a rare case. Identifying this condition without a typical history of underlying predisposition is important to avoid delaying emergent surgery as the key therapy.

Keywords: atraumatic, acute compartment syndrome, systemic anticoagulation, case report

Introduction and importance

Compartment syndrome is a well-known surgical emergency due to increased pressure within a fascial or osteo-fascial compartment, causing vascular compromise, and leading to ischemia and necrosis. [1] [2] [3] Acute compartment syndrome (ACS) generally occurs following a traumatic incident, but spontaneous compartment syndrome (without predisposing event), while infrequent, can also happen. [4] [5] [6] In addition, compartment syndrome occurring spontaneously as a complication of systemic anticoagulation is rare.[6] Few reports of acute compartment syndrome occurring spontaneously are published in the literature. A systematic review in 2019 showed that only 16 reports of spontaneous atraumatic ACS of the upper extremity were published from 1993 to 2016. [7] Quick identification and decompression in this setting are crucial to prevent irreversible damage. This case report has been reported in line with the SCARE Criteria. [8]

Case presentation

We report a case of a 51-year-old male with crescendo chest pain presented at the referral hospital. He was previously diagnosed with chronic coronary syndrome and hypertension but refused coronary intervention. Otherwise, VAS (visual analog scale) of 8/10, vital signs and physical exam were within normal limit. Chest X-ray within normal limit (figure 1). There was T wave inversion at the inferior and lateral lead on his ECG (figure 2). Laboratory work showed an elevated serum creatinine level of 8.13 mg/dL and a significant elevation of HsTrop 289.6 ng/L (over 99 th percentile). He was then diagnosed as NSTEACS high risk and treated with double antiplatelet in loading dose (300 mg of aspirin and 300 mg of clopidogrel 300 mg) and enoxaparin 60 mg twice daily despite significant reduced estimated glomerular filtration rate of 9 ml/min.m2. After 3 days of care with nonsignificant improvement, he was referred to our hospital for further intervention.

We perform laboratory work by blood drawing on the right cubital vein. Echocardiography showed normal kinetic with a preserved ejection fraction of 62%. He was further planned to undergo the early invasive strategy. However, within 2 hours of our care, there was significant swelling and tensing in his right (nontraumatic) brachial and antebrachial area (figure 3). In the next 2 hours, his swollen worsened into ecchymosis with bullae, and distal digital fingers developed pallor and paresthesia with decreased peripheral saturation of 88-91% (figure 4). We discontinue enoxaparin and proceed with single antiplatelet aspirin as recommended by ESC guidelines for NSTEACS 2020. He was then diagnosed with acute spontaneous compartment syndrome and planned to undergo fasciotomy.

Postoperatively, his symptoms improve (figure 5). We proceed with a conservative strategy for his NSTEACS due to exposed fascia with active bleeding, which is a contraindication to antiplatelets if he was planned for coronary stenting.

Clinical discussion

Compartment syndrome is caused by markedly increased pressure through a closed space (compartment) that disrupts local circulation, bearing decreased perfusion within the compartment. [2][3] This condition is generally associated with risk factors, commonly comprising fractures, burns, venous obstruction, vascular injuries, or compressive casts as traumatic events. [2][4] Increased compartment pressure can be induced by either an increase in volume within a fixed compartment size or a decrease in compartment size. The increasing pressure first jeopardizes microcirculatory perfusion. Nonetheless, as the pressure rises, lymphatic, capillary, and tiny venule flow decreases, leading to compromise venous and arterial blood flow, resulting in tissue ischemia and necrosis. This disorder can lead to fibrous tissue deterioration, neurological impairment, contractures, and even amputation if not treated promptly. As vascular flow decreases, the pressure within the compartment rises, resulting in a vicious cycle of edema worsening.[2] [4] [5]

The process shown by the aforementioned ailment is a vicious cycle of raising tissue pressure, causing ischemia, and irreversibly breaking down muscle. Because compartment syndrome is a clinical diagnosis, imaging approaches have limited diagnostic utility. [4] This illness's diagnosis is based on clinical judgments. Discomfort that was out of proportion to the damage, palpable swelling, pain on passive stretch test, focal motor or sensory deficits, and pulselessness were all present in the patient. Pulselessness and paralysis are late indicators of irreversible injury. [2] [4] [5] A diagnostic sensitivity of 93 percent is associated with the combination of pain with passive stretch, paresthesia, and pain at rest, with paresis boosting sensitivity to 98 percent. [2]

Double-check data about the injury's history, such as risk factors and symptom changes, is crucial. Early indications and symptoms are often subtle, and only aware patients may detect them. The first sign is excruciating pain that is out of proportion to the test. Patients report the pain as intense, searing, and deep, which is increased by passive stretching. Pain is a subjective experience with little sensitivity, which is terrible. Side effects such as paresthesias, sensory abnormalities, and focal motor weakness are also possible. [2]

Several case reports have described common causes of acute compartment syndrome without triggering traumatic events.[3] The mechanism of spontaneous acute compartment syndrome is unknown; however, a microvascular rupture in a patient with vasculopathy and high-risk bleeding (hemophilia, atypical localized infections, disseminated intravascular coagulation) induce gradual blood accumulation in the extremities compartment may cause acute compartment syndrome. Concurrent anticoagulation administration and all conditions impeding blood coagulation may increase the risk of this hypothetical pathophysiology. [3] As in our case, the patient was diagnosed with NSTEACS with impaired renal function (estimated glomerular filtration rate 7 ml/min/1.73m^2) and wrongly received a twice-daily therapeutic dose of enoxaparin, a factor Xa inhibitor with a half-life of 7 hours in normal renal function. Enoxaparin was recommended to be administered with dosage modification in a patient with eGFR less than 30 mL/min. A calculated GRACE score of 57, as a parameter of bleeding risk in a patient with NSTEACS, further worsens the patient coagulation profile and adjoin his risk of developing spontaneous compartment syndrome. Atraumatic compartment syndrome, in which atraumatic exercise causes an increase in intramuscular pressure, has received just a few reports. [4][5]

Only a few reports of nontraumatic acute compartment syndrome have been described in the literature. Atraumatic acute compartment syndrome is a difficult diagnosis to make because the triggering causes are unknown. [6] [7]

The arm comprises the anterior (biceps), posterior (triceps), and smaller deltoid compartments. Even though the anterior and posterior compartments can tolerate huge amounts of fluid, compartment syndrome can still develop. The ulnar and median nerves are located in the anterior compartment, as are the elbow flexor muscles. The radial nerve and the elbow's extensor muscles are both housed in the posterior compartment. The abductor muscles and axillary nerve are both housed in the deltoid compartment. [1] Deep volar compartment muscles (flexor pollicis longus and flexor digitorum profundus) and the median nerve are frequently damaged in the forearm compartments. [6]

If the diagnosis of compartment syndrome is incorrect, major problems can occur, including severe muscular atrophy, loss of feeling, and even amputation. Because the clinical signal may not be clear in atraumatic situations, establishing a diagnosis might be difficult. A comprehensive history taking and physical examination must be accompanied by recognizing that nontraumatic compartment syndrome may be present. [5] When acute compartment syndrome of the upper extremities occurs for no apparent reason, the doctor should suspect an undetected bleeding condition. [7]

This case depicts the development of events in a compartment syndrome that developed unexpectedly rather than as a result of a traumatic incident. This example demonstrates how anticoagulant usage can produce spontaneous bleeding, resulting in limb amputation (compartment syndrome) and perhaps death. Even if there is no history of trauma, patients with

recognized risk factors and symptoms of acute compartment syndrome should be evaluated and consulted for surgery as soon as possible. In such cases, a strong suspicion, rapid diagnosis, and prompt surgery are the keys to avoiding serious consequences.

Strength and Limitation: There are limited reports on the compartment syndrome of atraumatic origin in which nontraumatic event leads to an abnormal increase in intramuscular pressure. Atraumatic acute compartment syndrome is a challenging diagnosis as the precipitating elements are not widely known. These cases can very easily be neglected, and prompt treatment could be delayed.

Conclusion

Atraumatic acute compartment syndrome is an illness that requires prompt diagnosis and emergency treatment to avoid complications and preserve limb function. It is crucial to detect this condition to prevent postponing surgical surgery without a usual history of traumatic incident or underlying risk factors. Emergency decompression is recommended since a delay in diagnosis can result in long-term problems and the need for additional surgical treatments. Clinical examination is still the most important despite current research on new diagnostic techniques. Early fasciotomy is the only effective treatment for preventing lasting impairments, which emphasizes the necessity of rapid diagnosis and action.

Learning points

- There are limited reports on the compartment syndrome of atraumatic origin.
- Concurrent anticoagulation administration and all conditions that impairs blood coagulation may increase the risk of this hypothetical pathophysiology.
- Atraumatic acute compartment syndrome is a challenging diagnosis as the precipitating elements are not widely known.
- These cases can very easily be neglected and prompt treatment could be delayed.

- Conflicts of interest

None to declared

- Sources of funding

None to declared

- Ethical approval

N/a

- Consent

Written informed consent was obtained from the patient for publication of this case report and accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal on request.

- Author contribution

DNG contributed to the data collection and drafted the initial manuscript. DS contributed to the conceptualization and design of the study and drafted the initial manuscript. DNG and MA contributed to the data analysis and interpretation and revised the manuscript for important intellectual content.

- Research registration

N/a

- Guarantor

MA are the guarantor for this case report.

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[8] R.A. Agha, T. Franchi, C. Sohrabi, G. Mathew, A. Kerwan, A. Thoma, A.J. Beamish, A. Noureldin, A. Rao, B. Vasudevan, B. Challacombe, B. Perakath, B. Kirshtein, B. Ekser, C.S. Pramesh, D.M. Laskin, D. Machado-Aranda, D. Miguel, D. Pagano, F.H. Millham,

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Figure legends

Figure 1. Normal chest X-Ray

Figure 2. ECG showed ischemia at inferior and lateral leads

Figure 3. Swollen and tensing right arm

Figure 4. Bullae and echymosis during progression

Figure 5. Post fasciotomy

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Abstract

Introduction and importance: Compartment syndrome is a well-known surgical emergency caused by increasing pressure inside the fascial or osteo-fascial compartment, resulting in vascular compromise, ischemia, and necrosis. This condition usually occurs following a traumatic incident. Here we present a report of nontraumatic acute compartment syndrome caused by systemic anticoagulation in patients presenting with the acute coronary syndrome.

Case presentation: We report a case of a 51-year-old male with acute coronary syndrome receiving systemic anticoagulation, which later developed significant swelling and tensing on his right arm. He also complained of pallor and paresthesia with decreased peripheral oxygen saturation on his right arm.

Clinical discussion: The patient was diagnosed with atraumatic acute compartment syndrome and underwent fasciotomy promptly. His symptoms improved after undergoing fasciotomy.

Conclusions: Atraumatic acute compartment syndrome is a rare case. Identifying this condition without a typical history of underlying predisposition is important to avoid delaying emergent surgery as the key therapy.

Keywords: atraumatic, acute compartment syndrome, systemic anticoagulation, case report

Introduction and importance

Compartment syndrome is a well-known surgical emergency due to increased pressure within a fascial or osteo-fascial compartment, causing vascular compromise, and leading to ischemia and necrosis. [1] [2] [3] Acute compartment syndrome (ACS) generally occurs following a traumatic incident, but spontaneous compartment syndrome (without predisposing event), while infrequent, can also happen. [4] [5] [6] In addition, compartment syndrome occurring spontaneously as a complication of systemic anticoagulation is rare.[6] Few reports of acute compartment syndrome occurring spontaneously are published in the literature. A systematic review in 2019 showed that only 16 reports of spontaneous atraumatic ACS of the upper extremity were published from 1993 to 2016. [7] Quick identification and decompression in this setting are crucial to prevent irreversible damage. This case report has been reported in line with the SCARE Criteria. [8]

Case presentation

We report a case of a 51-year-old male with crescendo chest pain presented at the referral hospital. He was previously diagnosed with chronic coronary syndrome and hypertension but refused coronary intervention. Otherwise, VAS (visual analog scale) of 8/10, vital signs and physical exam were within normal limit. Chest X-ray within normal limit (figure 1). There was T wave inversion at the inferior and lateral lead on his ECG (figure 2). Laboratory work showed an elevated serum creatinine level of 8.13 mg/dL and a significant elevation of HsTrop 289.6 ng/L (over 99 th percentile). He was then diagnosed as NSTEACS high risk and treated with double antiplatelet in loading dose (300 mg of aspirin and 300 mg of clopidogrel 300 mg) and enoxaparin 60 mg twice daily despite significant reduced estimated glomerular filtration rate of 9 ml/min.m2. After 3 days of care with nonsignificant improvement, he was referred to our hospital for further intervention.

We perform laboratory work by blood drawing on the right cubital vein. Echocardiography showed normal kinetic with a preserved ejection fraction of 62%. He was further planned to undergo the early invasive strategy. However, within 2 hours of our care, there was significant swelling and tensing in his right (nontraumatic) brachial and antebrachial area (figure 3). In the next 2 hours, his swollen worsened into ecchymosis with bullae, and distal digital fingers developed pallor and paresthesia with decreased peripheral saturation of 88-91% (figure 4). We discontinue enoxaparin and proceed with single antiplatelet aspirin as recommended by ESC guidelines for NSTEACS 2020. He was then diagnosed with acute spontaneous compartment syndrome and planned to undergo fasciotomy.

Postoperatively, his symptoms improve (figure 5). We proceed with a conservative strategy for his NSTEACS due to exposed fascia with active bleeding, which is a contraindication to antiplatelets if he was planned for coronary stenting.

Clinical discussion

Compartment syndrome is caused by markedly increased pressure through a closed space (compartment) that disrupts local circulation, bearing decreased perfusion within the compartment. [2][3] This condition is generally associated with risk factors, commonly comprising fractures, burns, venous obstruction, vascular injuries, or compressive casts as traumatic events. [2][4] Increased compartment pressure can be induced by either an increase in volume within a fixed compartment size or a decrease in compartment size. The increasing pressure first jeopardizes microcirculatory perfusion. Nonetheless, as the pressure rises, lymphatic, capillary, and tiny venule flow decreases, leading to compromise venous and arterial blood flow, resulting in tissue ischemia and necrosis. This disorder can lead to fibrous tissue deterioration, neurological impairment, contractures, and even amputation if not treated promptly. As vascular flow decreases, the pressure within the compartment rises, resulting in a vicious cycle of edema worsening.[2] [4] [5]

The process shown by the aforementioned ailment is a vicious cycle of raising tissue pressure, causing ischemia, and irreversibly breaking down muscle. Because compartment syndrome is a clinical diagnosis, imaging approaches have limited diagnostic utility. [4] This illness's diagnosis is based on clinical judgments. Discomfort that was out of proportion to the damage, palpable swelling, pain on passive stretch test, focal motor or sensory deficits, and pulselessness were all present in the patient. Pulselessness and paralysis are late indicators of irreversible injury. [2] [4] [5] A diagnostic sensitivity of 93 percent is associated with the combination of pain with passive stretch, paresthesia, and pain at rest, with paresis boosting sensitivity to 98 percent. [2]

Double-check data about the injury's history, such as risk factors and symptom changes, is crucial. Early indications and symptoms are often subtle, and only aware patients may detect them. The first sign is excruciating pain that is out of proportion to the test. Patients report the pain as intense, searing, and deep, which is increased by passive stretching. Pain is a subjective experience with little sensitivity, which is terrible. Side effects such as paresthesias, sensory abnormalities, and focal motor weakness are also possible. [2]

Several case reports have described common causes of acute compartment syndrome without triggering traumatic events.[3] The mechanism of spontaneous acute compartment syndrome is unknown; however, a microvascular rupture in a patient with vasculopathy and high-risk bleeding (hemophilia, atypical localized infections, disseminated intravascular coagulation) induce gradual blood accumulation in the extremities compartment may cause acute compartment syndrome. Concurrent anticoagulation administration and all conditions impeding blood coagulation may increase the risk of this hypothetical pathophysiology. [3] As in our case, the patient was diagnosed with NSTEACS with impaired renal function (estimated glomerular filtration rate 7 ml/min/1.73m^2) and wrongly received a twice-daily therapeutic dose of enoxaparin, a factor Xa inhibitor with a half-life of 7 hours in normal renal function. Enoxaparin was recommended to be administered with dosage modification in a patient with eGFR less than 30 mL/min. A calculated GRACE score of 57, as a parameter of bleeding risk in a patient with NSTEACS, further worsens the patient coagulation profile and adjoin his risk of developing spontaneous compartment syndrome. Atraumatic compartment syndrome, in which atraumatic exercise causes an increase in intramuscular pressure, has received just a few reports. [4][5]

Only a few reports of nontraumatic acute compartment syndrome have been described in the literature. Atraumatic acute compartment syndrome is a difficult diagnosis to make because the triggering causes are unknown. [6] [7]

The arm comprises the anterior (biceps), posterior (triceps), and smaller deltoid compartments. Even though the anterior and posterior compartments can tolerate huge amounts of fluid, compartment syndrome can still develop. The ulnar and median nerves are located in the anterior compartment, as are the elbow flexor muscles. The radial nerve and the elbow's extensor muscles are both housed in the posterior compartment. The abductor muscles and axillary nerve are both housed in the deltoid compartment. [1] Deep volar compartment muscles (flexor pollicis longus and flexor digitorum profundus) and the median nerve are frequently damaged in the forearm compartments. [6]

If the diagnosis of compartment syndrome is incorrect, major problems can occur, including severe muscular atrophy, loss of feeling, and even amputation. Because the clinical signal may not be clear in atraumatic situations, establishing a diagnosis might be difficult. A comprehensive history taking and physical examination must be accompanied by recognizing that nontraumatic compartment syndrome may be present. [5] When acute compartment syndrome of the upper extremities occurs for no apparent reason, the doctor should suspect an undetected bleeding condition. [7]

This case depicts the development of events in a compartment syndrome that developed unexpectedly rather than as a result of a traumatic incident. This example demonstrates how anticoagulant usage can produce spontaneous bleeding, resulting in limb amputation (compartment syndrome) and perhaps death. Even if there is no history of trauma, patients with

recognized risk factors and symptoms of acute compartment syndrome should be evaluated and consulted for surgery as soon as possible. In such cases, a strong suspicion, rapid diagnosis, and prompt surgery are the keys to avoiding serious consequences.

Strength and Limitation: There are limited reports on the compartment syndrome of atraumatic origin in which nontraumatic event leads to an abnormal increase in intramuscular pressure. Atraumatic acute compartment syndrome is a challenging diagnosis as the precipitating elements are not widely known. These cases can very easily be neglected, and prompt treatment could be delayed.

Conclusion

Atraumatic acute compartment syndrome is an illness that requires prompt diagnosis and emergency treatment to avoid complications and preserve limb function. It is crucial to detect this condition to prevent postponing surgical surgery without a usual history of traumatic incident or underlying risk factors. Emergency decompression is recommended since a delay in diagnosis can result in long-term problems and the need for additional surgical treatments. Clinical examination is still the most important despite current research on new diagnostic techniques. Early fasciotomy is the only effective treatment for preventing lasting impairments, which emphasizes the necessity of rapid diagnosis and action.

Learning points

- There are limited reports on the compartment syndrome of atraumatic origin.
- Concurrent anticoagulation administration and all conditions that impairs blood coagulation may increase the risk of this hypothetical pathophysiology.
- Atraumatic acute compartment syndrome is a challenging diagnosis as the precipitating elements are not widely known.
- These cases can very easily be neglected and prompt treatment could be delayed.

- Conflicts of interest

None to declared

- Sources of funding

None to declared

- Ethical approval

N/a

- Consent

Written informed consent was obtained from the patient for publication of this case report and accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal on request.

- Author contribution

DNG contributed to the data collection and drafted the initial manuscript. DS contributed to the conceptualization and design of the study and drafted the initial manuscript. DNG and MA contributed to the data analysis and interpretation and revised the manuscript for important intellectual content.

- Research registration

N/a

- Guarantor

MA are the guarantor for this case report.

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G. Roy, H. Kadioglu, I.J. Nixon, I. Mukherjee, J.A. McCaul, J. Chi-Yong Ngu, J. Albrecht, J.G. Rivas, K. Raveendran, L. Derbyshire, M.H. Ather, M.A. Thorat, M. Valmasoni, M. Bashashati, M. Chalkoo, N.Z. Teo, N. Raison, O.J. Muensterer, P.J. Bradley, P. Goel, P.S. Pai, R.Y. Afifi, R.D. Rosin, R. Coppola, R. Klappenbach, R. Wynn, R.L. De Wilde, S. Surani, S. Giordano, S. Massarut, S.G. Raja, S. Basu, S.A. Enam, T.G. Manning, T. Cross, V.K.L. Karanth, V. Kasivisvanathan, Z. Mei, The SCARE 2020 Guideline: Updating Consensus Surgical CAse REport (SCARE) Guidelines, Int. J. Surg. 84 (2020) 226–230. https://doi.org/https://doi.org/10.1016/j.ijsu.2020.10.034.

Figure legends

Figure 1. Normal chest X-Ray

Figure 2. ECG showed ischemia at inferior and lateral leads

Figure 3. Swollen and tensing right arm

Figure 4. Bullae and echymosis during progression

Figure 5. Post fasciotomy

Figure

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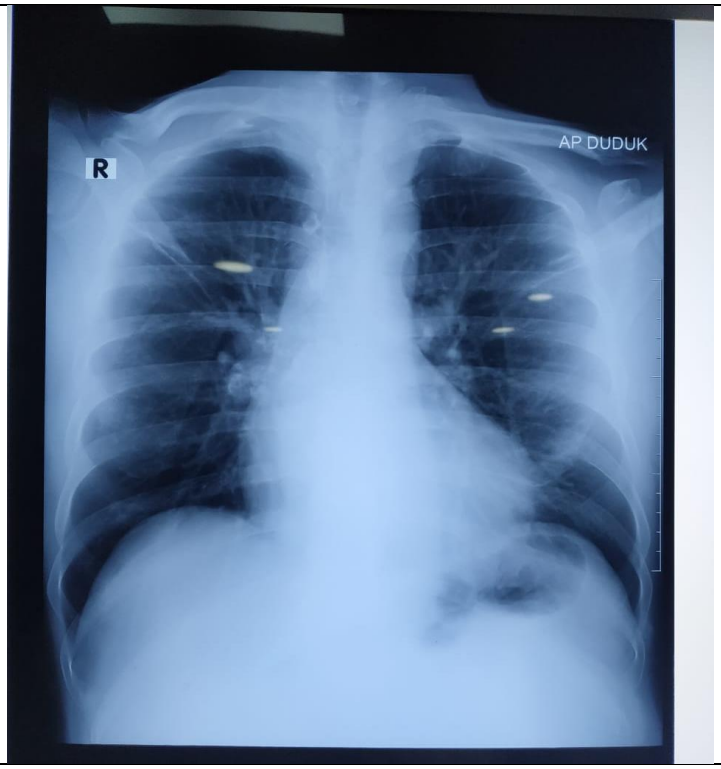


Figure 1. Normal chest X-Ray

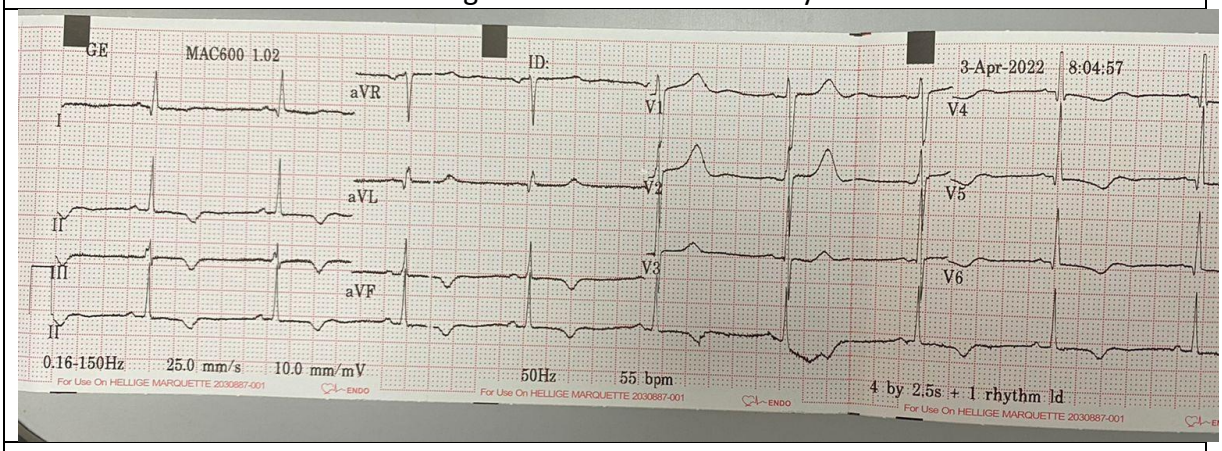


Figure 2. ECG showed ischemia at inferior and lateral leads

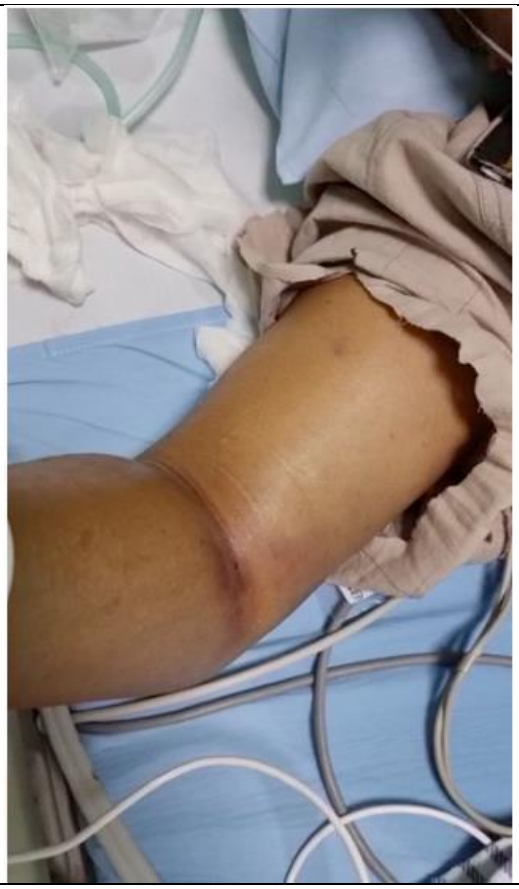
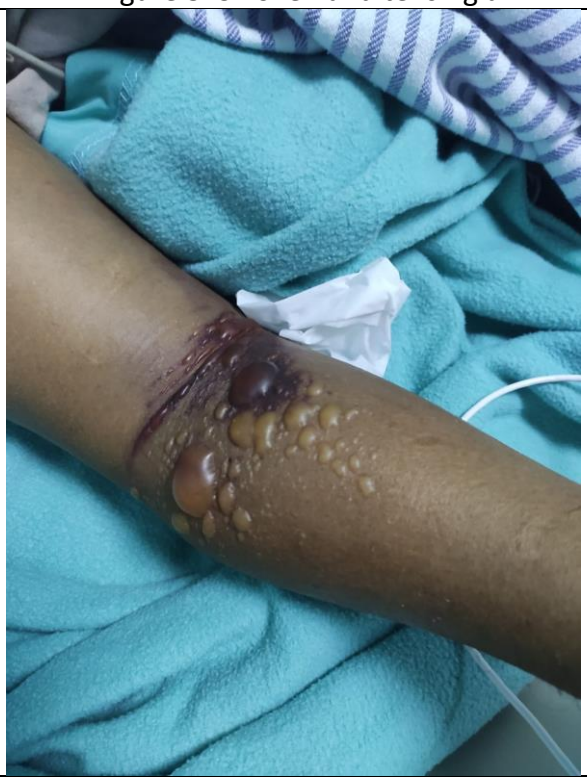


Figure 3. Swollen and tensing arm



Fugre 4, Bullae and echymosis during progression

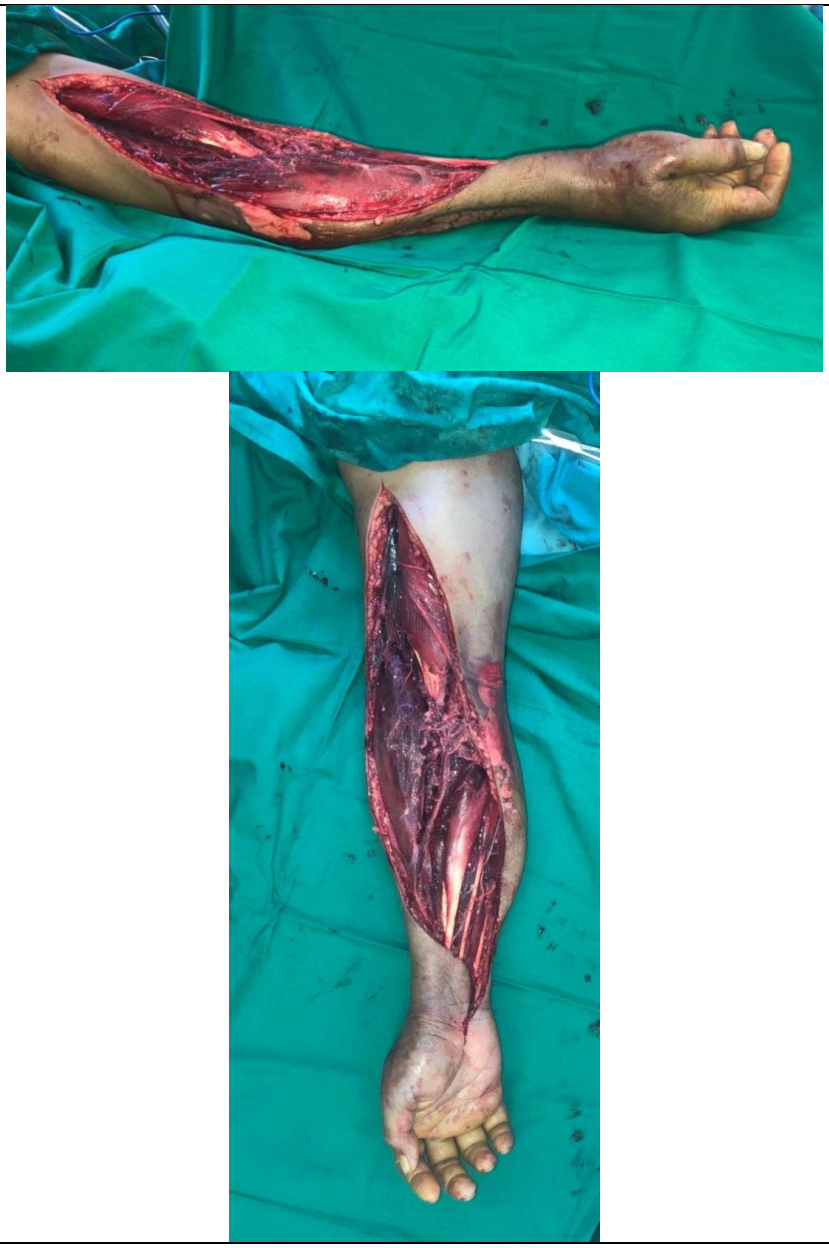


Figure 5. Post Fasciotomy

SCARE 2020 Checklist			
Topic	**Item**	**Checklist Item Description**	**Page Number**
Title	**1**	- The words 'case report' should appear in the title. The title should also describe the area of focus (e.g. presentation, patient population, diagnosis, surgical intervention or outcome).	1
Key Words	**2**	- Include three to six keywords that identify what is covered in the case report (e.g. patient population, diagnosis or surgical intervention). - Include 'case report' as one of the keywords.	1
Abstract	**3a**	Introduction and Importance - Describe what is important, unique or educational about the case, and what does this add to the surgical literature.	1
	3b	Case Presentation - Presenting complaints, clinical and demographic details, and the patient's main concerns.	1
	3c	Clinical Findings and Investigations - Clinical findings, investigations performed, main differentials, and subsequent diagnosis.	1
	3d	Interventions and Outcome - Describe the rationale for choosing the intervention. - Describe what was the end result.	1
	3e	Relevance and Impact - Describe the main take-away lessons or potential implications for clinical practice (minimum of three).	1
Introduction	**4**	Background - Describe briefly the area of focus and the relevant background contextual knowledge. Rationale - Describe why the case is different to what is already known and why it is important to report?	1

		- Is the case rare or interesting for the specific healthcare setting, population or country, or is it applicable globally? Guidelines and Literature - Give reference to relevant surgical literature and current standards of care, including any specific guidelines.	
Patient Information	**5a**	Demographic Details - Include de-identified demographic details of the patient (e.g. age, sex, ethnicity, occupation). - Where possible, include other useful pertinent information (e.g. body mass index, hand dominance, income, level of education, marital status).	**3**
	5b	Presentation - Describe the patient's presenting complaint. - Include a collateral account of the history if relevant. - Describe the patient's mode of presentation (e.g. self-presentation, ambulance or referred by family physician or other hospital clinicians).	3
	5c	Past Medical and Surgical History - Include any previous interventions and relevant outcomes.	3
	5d	Drug History and Allergies - Specify any acute, repeat, and discontinued medications. - Include any allergies and/or adverse reactions.	3
	5e	Family History - Health information regarding first-degree relatives, specifying any inheritable conditions. Social History - Indicate smoking, alcohol, and recreational drug use. - Level of social independence, driving status, and type of accommodation. Review of Systems - If appropriate, report on any other information gathered outside of the focused history.	3

Clinical Findings	**6**	- Describe the general and significant clinical findings based on initial inspection and physical examination.	3
Timeline	**7**	- Summarise the sequence of events leading up to the patient's presentation. - Delays from presentation to diagnosis and/or intervention should be reported. - Use tables or figures to illustrate the timeline of events if needed.	3
Diagnostic Assessment and Interpretation	**8a**	Diagnostic Assessment - Bedside (e.g. urinalysis, electrocardiography, echocardiography). - Laboratory (e.g. biochemistry, haematology, immunology, microbiology, histopathology). - Imaging (e.g. ultrasound, X-ray, CT/MRI/PET). - Invasive (e.g. endoscopy, biopsy).	3
	8b	Diagnostic Challenges - Where applicable, describe what was challenging about the diagnoses (e.g. access, financial, cultural).	3
	8c	Diagnostic Reasoning - Describe the differential diagnoses, why they were considered, and why they were excluded.	3
	8d	Prognostic Characteristics - Include where applicable (e.g. tumour staging).	3
Intervention	**9a**	Pre-Operative Patient Optimisation - Lifestyle (e.g. weight loss). - Medical (e.g. medication review, treating any relevant pre-existing medical concerns). - Procedural (e.g. nil by mouth, enema). - Other (e.g. psychological support).	3
	9b	Surgical Interventions - Describe the type(s) of intervention(s) used (e.g. pharmacological, surgical, physiotherapy, psychological, preventative).	3

		- Describe any concurrent treatments (e.g. antibiotics, analgesia, antiemetics, venous thromboembolism prophylaxis). - Medical devices should have manufacturer and model specifically mentioned.	
	9c	Specific Details regarding Interventions - Describe the rationale behind the treatment offered, how it was performed and time to intervention. - For surgery, include details on the intervention (e.g. anaesthesia, patient position, preparation used, use of other relevant equipment, sutures, devices, surgical stage). - The degree of novelty for a surgical technique/device should be mentioned (e.g. 'first in human'). - For pharmacological therapies, include information on the formulation, dosage, strength, route, and duration.	3
	9d	Operator Details and Setting of Intervention - Where applicable, include operator experience and position on the learning curve, prior relevant training, and specialisation (e.g. 'junior trainee with 3 years of surgical specialty training'). - Specify the setting in which the intervention was performed (e.g. district general hospital, major trauma centre).	3
	9e	Deviation from Initial Management Plan - State if there were any changes in the planned intervention(s), and describe these alongside the rationale (e.g. delays to intervention).	3
Follow-Up and Outcomes	**10a**	Specify Details regarding the Follow-Up - When (e.g. how long after discharge, frequency, maximum follow-up length at time of submission). - Where (e.g. home via video consultation, primary care, secondary care). - How (e.g. telephone consultation, clinical examination, blood tests, imaging).	3

		- Any specific long-term surveillance requirements (e.g. imaging surveillance of endovascular aneurysm repair or clinical exam/ultrasound of regional lymph nodes for skin cancer). - Any specific post-operative instructions (e.g. post-operative medications, targeted physiotherapy, psychological therapy).	
	10b	Intervention Adherence and Compliance - Where relevant, detail how well the patient adhered to and tolerated the advice provided (e.g. avoiding heavy lifting for abdominal surgery, or tolerance of chemotherapy and pharmacological agents). - Explain how adherence and tolerance were measured.	3
	10c	Outcomes - Expected versus attained clinical outcome as assessed by the clinician. Reference literature used to inform expected outcomes. - When appropriate, include patient-reported measures (e.g. questionnaires including quality-of-life scales).	3
	10d	Complications and Adverse Events - Precautionary measures taken to prevent complications (e.g. antibiotic or venous thromboembolism prophylaxis). - All complications and adverse or unanticipated events should be described in detail and ideally categorised in accordance with the Clavien-Dindo Classification (e.g. blood loss, length of operative time, wound complications, re-exploration or revision surgery). - If relevant, was the complication reported to the relevant national agency or pharmaceutical company. - Specify the duration of time between completion of the intervention and discharge, and whether this was within the expected timeframe (if not, why not). - Where applicable, the 30-day post-operative and long-term morbidity/mortality may need to be specified. - State if there were no complications or adverse outcomes.	3

Discussion	**11a**	Strengths - Describe the relevant strengths of the case. - Detail any multidisciplinary or cross-speciality relevance.	7
	11b	Weaknesses and Limitations - Describe the relevant weaknesses or limitations of the case. - For novel techniques or devices, outline any contraindications and alternatives, potential risks and possible complications if applied to a larger population.	7
	11c	Relevant Literature - Include a discussion of the relevant literature and, if appropriate, similar published cases. - Describe the implications for clinical practice guidelines and any relevant hypotheses generated.	4
	11d	- Provide a rationale for the conclusions drawn from the case.	4
	11e	Take-Away Lessons - Outline the key clinical lessons from this case report. - Discuss any differences in approach to diagnosis or patient management which the authors might adopt in future similar cases, based on their experience of the case.	8
Patient Perspective	**12**	- Where appropriate, the patient should be given the opportunity to share their perspective on the intervention(s) they received (e.g. sharing quotes from a consented and anonymised interview).	N/A
Informed Consent	**13**	- The authors must provide evidence of consent, where applicable, and if requested by the journal. - State the method of consent at the end of the article (e.g. verbal or written). - If not provided by the patient, explain why (e.g. death of patient and consent provided by next of kin). If the patient or family members were untraceable then document the tracing efforts undertaken.	9

Additional Information	**14**	- Please state any author contributions, acknowledgments, conflicts of interest, sources of funding, and where required, institutional review board or ethical committee approval. - Disclose whether the case has been presented at a conference or regional meeting.	9
Clinical Images and Videos	**15**	- Where relevant and available, include clinical images to help demonstrate the case pre-, peri-, and post-intervention (e.g. radiological, histopathological, patient photographs, intraoperative images). - Where relevant and available, include a link (e.g. Google Drive, YouTube) to the narrated operative video can be included to highlight specific techniques or operative findings. - Ensure all media files are appropriately captioned and indicate points of interest to allow for easy interpretation.	13, figure 1-5
Referencing the Checklist	**16**	- Include reference to the SCARE 2020 publication by stating: ‘This case report has been reported in line with the SCARE Criteria [include citation]’ at the end of the introductory section.	2