Author's response to reviews

Title: Case report: Infective endocarditis caused by Brevundimonas vesicularis

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Re: 2095928401146748 - Case report: Infective endocarditis caused by Brevundimonas vesicularis

Dear Editors,

A point-by-point response to the peer reviews of our revised manuscript, #2095928401146748, is presented in this reply letter according to the editors' suggestion. All authors have read and agreed to the re-submitted version of the manuscript. The reviewers' queries and suggestions are addressed item by item as follows, highlighted in Bold format:

Reviewer Jacob Gilad

Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)

1. The conclusion in the abstract still needs some rephrasing. For example: "According to our experience and the literature review, data regarding the optimal therapy of BV infection are limited. Current evidence support a favorable result with third generation cephalosporins, piperacillin-tazobactam and ciprofloxacin, while the efficacy of ampicillin-sulbactam needs further evaluation".
   The conclusion in the abstract is revised according to the reviewer's suggestion. (Page 2, the last paragraph)

2. Should state according to Duke's criteria whether SBE in this case is definite, probable, possible...
   Definite SBE, diagnosed according to Duke's criteria, is stated in the revised article. (Page 5, line1)

3. Disk diffusion - state that plates were read after >24h of incubation contrary to CLSI recommendation for Pseudomonas. The limitation of A/S testing without an MIC method should be better explained. This contradicts the current statement that A/S is not suitable for BV.
For treatment of endocarditis, MIC, MBC, and serum bactericidal titer determination would be helpful and appropriate to guide antimicrobial therapy. The discussion about antimicrobial susceptibility methodology limitation is stated in line 3-11 of page 8.

4. I still believe that such a case should be treated for 6 weeks and that gentamicin doses should have been higher.
We agree that SBE caused by Pseudomonas spp. should be appropriately treated for 6 weeks, sufficient to eradicate microorganisms growing within the valvular vegetations. Discussion about the optimal duration for treatment of B. vesicularis SBE is added in the line 3-6 on page 9.
The dosage of gentamicin in combination therapy for endocarditis in an adult with normal renal function is 1.0-1.5 mg/kg, q8h according to the suggestion from "The Sanford Guide to Antimicrobial Therapy, 2006, 36th ed, page 22". Therefore, it is not inappropriate for the patient with body weight of 78 Kg to receive daily gentamicin dose of 240 mg. Of course, higher dosage of gentamicin, such as 350mg/d for a 70 Kg man, is also an appropriate choice. Considering the brevity of the case report, we do not add the viewpoint in the discussion part.

5. If femoral-inguinal symptoms are ascribed to embolism, state this explicitly.
The femoral-inguinal symptoms is stated in the revised article (page 6, line 6-7)

Many thanks to both reviewers' kindly instructive suggestions and corrections.

Yours sincerely,
Po-Liang Lu M.D.