Author’s response to reviews

Title: Solitary breast metastasis from myxoid liposarcoma.

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Author’s response to reviews:

Dear Editor:

Thank you very much for your valuable comments on our manuscript. We have comprehensively modified our paper in accordance with the reviewers’ comments and requests, and wish to resubmit the revised manuscript. The revised portions in the manuscript are denoted in red font.

Our replies to the reviewers’ comments are listed below.

Reviewer 1

Case presentation
On ultrasound, you could exclude macrocalcifications only. Microcalcifications cannot be diagnosed here. Please, correct.

# Following the reviewer’s comments on the case presentation, we have corrected the sentence as follows:
Original sentence,  
“No calcification was present.”
Revised sentence,  
“Macrocalcifications were not observed.”

Discussion
Well written and comprehensive. Please provide additional information which may be of interest for the reader:

For example: according to the literature, breast metastases occurred most frequently in malignant melanomas, sarcomas, lung cancers, ovarian tumors, renal carcinomas, and thyroid tumors (Surov et al., Acad Radiol 2012; Lee SK et
al. J Surg Oncol 2010; Muttarak M et al Australas Radiol 1998). Previous reports suggested that breast metastases from different primary tumors showed different radiological patterns. For instance, largest lesions occurred in rhabdomyosarcoma, followed by hepatocellular carcinoma and squamous cell carcinomas of the head and neck region. The smallest lesions arose from malignancies of the thyroid gland carcinoma. Most breast metastases showed circumscribed margins, while breast lesions in rhabdomyosarcoma were rather microlobulated. On ultrasound, metastases from lung cancer were usually inhomogeneously hypoechoic with circumscribed margins and showed posterior shadowing in almost 50% of the cases. Breast metastases from ovarian carcinoma had typically microlobulated margins and posterior enhancement (Abbas et al., Eur J Radiol 2013).

# In accordance with the reviewer’s comments about the discussion, we have added the following sentence:

“According to the literature, breast metastases occur more frequently in malignant melanomas, sarcomas, lung cancers, ovarian tumors, renal carcinomas, and thyroid tumors [3,11,12]. Previous reports have suggested that breast metastases from different primary tumors have distinct radiological patterns. For instance, the largest lesions occurred in rhabdomyosarcomas, followed by hepatocellular carcinomas and squamous cell carcinomas of the head and neck region. The smallest lesions occurred in thyroid gland carcinomas [13]. Most breast metastases showed circumscribed margins, while metastases from rhabdomyosarcomas were microlobulated [13]. On ultrasound, breast lesions in lung cancers were usually inhomogeneously hypoechoic with circumscribed margins and demonstrated posterior shadowing in almost 50% of the cases. Breast metastases from ovarian carcinomas have typically microlobulated margins and posterior enhancement [13].”

# In addition, we have cited the following references in the revised manuscript:


Reviewer 2
1. Language
a. There are too many abbreviations in the paper that are not standard. Please replace STS, HE and MLS with the words. It is inappropriate to invent new abbreviations and makes the paper hard to read.
b. Once defined, only the abbreviation should be used. Please check this throughout the paper for remaining abbreviations.

# In accordance with the reviewer’s comments about abbreviations, we have spelled out STS, HE, and MLS. In addition, we re-checked all abbreviations throughout the paper.

c. The abbreviations CT and MRI must be defined at their first use.

# As the reviewer recommended, we have defined the abbreviations CT and MRI at their first use.

2. Structure
a. I am concerned because there are 10 authors on a simple case report. This seems excessive and I would question whether all 10 authors meet the standards to be named as a co-author. The authors must justify this excessive list.

# In response to the reviewer's comments, we have reduced the number of co-authors. Since the patients were treated by two different departments (Orthopedic Surgery and Breast and Thyroid Surgery) and pathological confirmation was needed, we judged the remaining co-authors to be deeply involved in this study.

3. Science
a. TNMG staging of the original sarcoma should be stated clearly

# As the reviewer recommended, we have reported the TNMG staging of the original sarcoma (T2b N0 M0 G2: stage IIB) in the case presentation section.

b. Margins of resection in cm should be stated for the breast mass.

# As the reviewer recommended, we have reported the margins of resection for the breast mass (1 cm from the edge of the tumor) in the case presentation section.

c. The authors should justify their use of PET-CT in the evaluation of this patient. What is the sensitivity and specificity for PET-CT in the evaluation of a soft tissue sarcoma?

# In response to the reviewer’s comments about PET/CT, we have added the following sentence in the discussion section:

“PET/CT is widely used for staging in various malignancies, especially for nodal and distant metastasis staging. In general, sarcomas tend to be
18F-fluorodeoxyglucose avid and whole-body PET/CT is described as an ideal modality for staging malignant soft tissue sarcomas [9]. However, several recent studies have reported wide-ranging sensitivities and specificities for this method of detection of metastatic soft tissue sarcoma [19]. Although we used PET/CT in the preoperative evaluation of this patient, the utility of PET/CT for the staging of soft tissue sarcoma remains to be defined [19].

In addition, we have cited the following reference in the revised manuscript:


d. Most sarcomas recur in the lungs. A negative imaging study of the lungs would be an important negative finding and should be explicitly stated.

In response to the reviewer’s comments, we have revised the sentence in the case presentation section as follows:

Original sentence
“The patient’s postoperative course was uneventful, and no recurrence or new metastases were observed 5 years after resection of the metastatic lesion in the breast.”

Revised sentence
“The patient’s postoperative course was uneventful. Since most sarcomas recur in the lungs, the patient has been carefully observed with repeated total body CT imaging. No recurrence or new metastases in the lungs or elsewhere were observed in the 5 years after resection of the metastatic lesion in the breast.”

EDITORS COMMENTS
1. Page 5, near the bottom, states “myxoid liposarcoma patients” which in fact is common but incorrect English (this is extremely common in many papers but is absolutely incorrect). The expression should be “patients with myxoid liposarcoma”.

Done

2. The authors were requested to provide the TNMG stage, but failed to do so, providing only TNM staging, which is incomplete. In the AJCC/UICC staging manual, soft tissue sarcomas (unlike any other tumor) are staged with 4 characteristics, including Histologic Grade (G1, G2 or G3). Please refer to the latest edition of the staging manual and provide TNMG staging on page 4 as requested.

As the editor’s recommended, we have reported the TNMG staging of the original sarcoma (T2b N0 M0 G2: stage IIB) in the case presentation section.

We would appreciate your evaluation of our revised manuscript and look forward to your response.
Respectfully yours,

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