Author's response to reviews

Title: Gastrointestinal Stromal Tumour of the Duodenum in Childhood: A Rare Case Report

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Author’s response to reviews: see over
The Biomed Central Editorial Team (BMC Cancer)

Object: MS: 1705727549103876 “Gastrointestinal Stromal Tumour of the Duodenum in Childhood: A Rare Case Report”. Dr. Massimo Chiarugi et al.

Thank you for consideration of our manuscript for publication in your journal.

We have reviewed the above manuscript according to your reviewers’ comments.

Reviewer n. 1 (Dr. Markku Miettinen)

MINOR ESSENTIAL REVISIONS

1. There are a few pediatric GIST series that the authors did not mention.

   Three further series of pediatric GIST have been inserted and are now mentioned in the text (please see references 11, 12, 27)

2. Statement whether there is any evidence for familial GIST (other family members with GIST) or neurofibromatosis type 1 would complete clinical background.

   In the case presentation paragraph on page 2, the above suggested statements are now reported: “As diagnosis of GIST was made, the patient was investigated to detect clinical features of type 1 neurofibromatosis and of Carney’s triad (GIST associated with paraganglioma and pulmonary chordoma). Both syndromes were excluded. In addition, no other family members resulted affected by GIST.”

3. I would encourage the authors to perform KIT and PDGFRA mutation analysis. This would increase the value of this case report.

   Molecular genomic analysis to detect KIT and PDGFRA mutation has been carried-out on samples of tumor tissue, and it is described on page 2:” Molecular work-up on tumor tissue samples based on polymerase chain amplification followed by sequence analysis of selected coding sequences of KIT (exons 9, 11, and 13) and platelet-derived growth factor receptor α (PDGFRA; exons 12, 14, and 18) yielded no evidence of mutation.”
**Reviewer n. 2 (Dr. Anette Duensing)**

**MAJOR COMPULSORY REVISIONS**

1. The vast majority of adult GISTS are caused by mutations in the KIT or PDGFRα receptor tyrosine kinase genes, respectively. Mutational analysis or other diagnostic follow-up procedures were not performed for the present case. However, this is essential since pediatric GISTs appear to be a clinical and molecular entity than adult GISTs.

   Molecular analysis for KIT and PDGFRα genes mutation has been performed and the results are now reported on page 2:”Molecular work-up on tumor tissue samples based on polymerase chain amplification followed by sequence analysis of selected coding sequences of KIT (exons 9, 11, and 13) and platelet-derived growth factor receptor α (PDGFRα; exons 12, 14, and 18) yielded no evidence of mutation.”

2. The general difference between pediatric/adult and gastric/small bowel GISTs (different mutational status, histopathology, response to imatinib therapy) are not discussed.

   On page 3 a brief discussion concerning the abovementioned topics is now reported: “Treatment with imatinib, an inhibitor of receptor tyrosine kinases (RTKs), may be offered to pediatric patients with advanced GIST disease, not radically amenable by surgery. It has been suggested that mutation in the KIT or PDGFRα genes with a consequent alteration of the RTKs may correlate with a worse prognosis and a poorer response to therapy. [23,24,25] This seems to occur more frequently in adults for GIST arising from the small bowel or for those with pure spindle cell morphology. [26] In children genes mutations have been described in the cases of familial GISTS, but they do occur very rarely in sporadic GISTS. [11,12,27]” Authors are well aware that such important topics are presented in a very generic and not-specific manner. However the manuscript has been intended just as a case report, and a detailed speculation about histopathology and genetics of GISTs is far beyond the intent and also the capability of the Authors.

**MINOR ESSENTIAL REVISIONS**

1. The abbreviations used in the text should be introduced when first mentioned (e.g., US, TC…)

   - Done

2. According to the guidelines of BMC Cancer, written and signed consent forms should be included when reporting case reports and presenting clinical photographs. These consent forms were not included in the version of the manuscript that I received for review.
Being the patient under 18 yrs. a consent forms for clinical data and photographs publication was signed by parents and was faxed to BMC Editorial Team (Ms. Chantal Botha).

I wish to thank very much the reviewers for their comments. Whatever the fate of the manuscript, they have stimulated me to take a deeper vision of the GIST problem.

Sincerely yours,

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