Author's response to reviews

Title: A case report of syndrome of inappropriate antidiuretic hormone secretion with Castleman's disease and lymphoma

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Version: 3 Date: 24 February 2013

Author's response to reviews: see over
Dear Editor:

Thank you very much for considering our paper entitled “A case report of syndrome of inappropriate antidiuretic hormone secretion with Castleman’s disease and lymphoma” for publication in the *BMC Endocrine Disorders*.

As requested, we revised this paper very carefully and addressed every comment from the editor and the reviewers. We now think much improved. We hope you will find it suitable for publication in *BMC Endocrine Disorders*.

Please see below for point-by-point response to the reviewers.

Yours sincerely,
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**Point-by-point response:**

Commentary of the reviewer Michael Piagnerelli

Although the manuscript was improved, there are still difficulties in understanding the clinical case.

- Patient complaints about pain in the back and leg are not investigated at the start of the admission but a CT thorax was first performed? Clinical exam is essential to perform a diagnosis and not to look at SIADH etiology

> Thank you for your comment. The patient was admitted for uncontrolled hyperglycemia without any complaints about pain in the back and leg. On the seventh day after admission, the patient developed symptoms of nausea and vomiting. Hyponatremia was confirmed and leg pain was gradually presented. In order to find the reasons of hyponatremia, a series of tests were arranged. Because pulmonary carcinoma is a prominent cause of SIADH, the thorax CT scan was first performed. Thank you for your advice and we emphasized clinical exam for etiology in this revision.

- Why the authors have tried hydrocortisone when the values of adrenal function were at the normal values?

> The values of adrenal function were in the normal range. However, we did not completely exclude the hypopituitarism. The first reason was that the MRI of her pituitary gland showed herniation of the suprasellar cistern. The second reason was that the patient had insufficient adrenal function because of stress induced by pain. This information was amended in this revision.
The first line treatment of the SIADH is the hydration restriction. In this case report, it seems to be started after first treatment by hydrocortisone?

Agree. We had started the treatment with hydrocortisone before the diagnosis of SIADH was established. Our first impression had been hypopituitarism, and through the treatment with hydrocortisone, SIADH and hypopituitarism could be distinguished. After the failure of hydrocortisone treatment, hydration restriction was adopted. If the SIADH could be established at the beginning, we would have taken the treatment of hydration restriction. To improve clinical practice, we highlighted this important information in this revision.

I can not seem to understand when sodium goes up: is it the treatment with fluid restriction, treatment of Castleman's disease or lymphoma treatment? For the latter, it seems that the Na was already normalized. It might be easier to represent on a graph the evolution of the sodium and the beginning of the different treatments….

Comment accepted. The improvement of hyponatremia mainly depended on the fluid restriction as we described, however, that did not last very long. After the patient was transferred to the Department of Hematology for chemotherapy of CHOP with rituximab, the serum sodium could be sustained at a normal level. We added a graph to represent the evolution of the sodium in this revision.

If the authors discuss the different therapies of SIADH, the administration of urea must be discussed (eg: Coussement et al. Am J Kidney 2012).

With the major aim of diagnosing SIADH in time in clinical practice, we didn’t discuss different therapies of SIADH in much details. In this revision, we cited the important study of urea administration for critically ill patients.

Commentary of the reviewer Tomoaki Murakami

Thank you for your instructive comments.

This manuscript is redundant as case report. It is better to make it small by focusing on … SIADH?

Comment accepted. We removed some redundant content in the revision.

In theory, uOsm>100 is enough for SIADH. However, definite SIADH requires sOsm<280 and uOsm>300 in Japanese guideline for Dx and Tx of SIADH. This case is not “typical” SIADH, I think. High ADH with normal renal kidney function elevates uOsm. Was there renal damage (due to diabetes)? Normal serum creatinine value is not enough to prove normal renal function. Moreover, I’d like
to know the condition of diabetes (glucose level etc.) at onset.

Comment accepted. According to the Japanese guideline for SIADH, we admitted our case had atypical SIADH. We added some important values about renal function and the condition of diabetes at onset in the revision. Please see the blood glucose and HbA1c in Table 2. And kidney B- ultrasound revealed the left kidney size was 11.7*4.9 cm and the right kidney was 11.1*4.7 cm. There was no abnormal image of each kidney. Urinary protein excretion rate was calculated as 28.8ug/min.

The serum sodium change in current hospitalization

<table>
<thead>
<tr>
<th>time</th>
<th>Serum sodium value</th>
<th>management</th>
</tr>
</thead>
<tbody>
<tr>
<td>1\textsuperscript{st} day</td>
<td>137</td>
<td>Insulin etc.</td>
</tr>
<tr>
<td>7\textsuperscript{th} day</td>
<td>112</td>
<td>Hydrocortisone 50mg/day</td>
</tr>
<tr>
<td>8\textsuperscript{th} day</td>
<td>116</td>
<td>Fluid restriction</td>
</tr>
<tr>
<td>9\textsuperscript{th} day</td>
<td>128</td>
<td>The same as above</td>
</tr>
<tr>
<td>17\textsuperscript{th} day</td>
<td>142</td>
<td>The same as above</td>
</tr>
<tr>
<td>27\textsuperscript{th} day</td>
<td>130</td>
<td>Fluid restriction relaxed</td>
</tr>
</tbody>
</table>