Author's response to reviews

Title: Anterior chest wall tuberculous abscess: a case report

Authors:

Theodossis S Papavramidis (papavramidis@hotmail.com)
Vassilis N Papadopoulos (bnpap2003@yahoo.com)
Antonis Michalopoulos (amichal@med.auth.gr)
Daniel Paramythiotis (danosprx@med.auth.gr)
Stamatia Potsi (matinapotsi@hotmail.com)
Georgia Raptou (spapavra@med.auth.gr)
Anna Kaloger-Foutzila (kalogera@med.auth.gr)
Nick Harlaftis (papavramidou@hotmail.com)

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Author's response to reviews: see over
Dear Sir,

I send you the revised version of the case report: “Anterior chest wall tuberculous abscess: a case report”. Please consider the above article for possible publication in JMCRR. All reviewers’ comments were replied and a separate page for each reviewer follows.

Thank you in advance.

Yours Sincerely

Theodossis Papavramidis M.D.
Reply to Reviewers’ Comments

Reviewer: Nicholas Price

We would like to thank the reviewer for the time he spent considering our article.
Concerning the comments here is a point to point answer to the comments:

Comment 1: TB chest wall abscess is one of the more unusual manifestations of TB but when one considers that TB is one of the world's most common infections, it is really not particularly rare presentation.

I just quote the 2nd reviewers general comment in order to back the case report: “Although extra-pulmonary TB is not unusual (representing about a third of cases), the diagnosis is very frequently delayed or missed. This case highlights the indolent nature of TB and one of the many unusual presentations. There is a general lack of awareness of these unusual cases, particularly in younger clinicians in the West who may see TB infrequently. Even though a fair number of case reports of unusual TB presentations are published every year I think this case will contribute to raising awareness.”

Comment 2: Furthermore, the authors repeatedly state that TB is unusual in the immunocompetent, which is definitely not the case. We are told this patient is immunocompetent but there is no reference to an HIV test having been performed in the "Case Report".

We fully agree with the above mentioned comment. HIV test were performed indeed and in order to state this, a phrase was added in the case report.

Phrase added: “HIV test was performed and gave negative results.”

Comment 3: In a patient from the former USSR, I would be concerned about drug resistance and we are not told the drug sensitivity pattern. However, the patient is commenced on standard quadruple therapy but the drug doses as stated are incorrect (for any patient's weight).

We also were concerned about drug resistance that’s why there is a paragraph in the discussion. Indeed concerning the standard quadruple therapy, the treating doctor (Dr. Paramythiotis) responsible for the pharmaceutical treatment was asked to re-check the doses that he initially gave to us for the report. He said that the exact doses employed were as follows: Isoniazid (300mg), Rifampin (600mg), Pyrazinamide (2g), and Pyridoxine (50mg). Appropriate corrections were made.
Reply to Reviewers’ Comments
Reviewer: Ian Cropley

We would like to thank the reviewer for the time he spent considering our article. Concerning the comments we found that there were very constructive. Here is a point to point answer to the comments:

1. The authors state that TB is very rare in immunocompetent patients. I can’t find published evidence for this in the literature and it is not our experience in London. Is there a reference to back up this statement?
   Indeed, what we meant is that extrapulmonary TB is rarer in immunocompetent patients (Sharma SK, Mohan A. Extrapulmonary tuberculosis Indian J Med Res 2004;120:316-53). Appropriate changes were made at the abstract and the conclusion sections were the above-mentioned statement was made.

2. The authors state that TB must be confirmed by positive culture or histological proof. It would be better to rephrase this as in fact cultures may take up to six weeks to become positive, and TB treatment is often started immediately after the appropriate microbiological and histological samples have been obtained if the clinical suspicion is high. I agree it is very important to take the appropriate samples first.
   Indeed, TB treatment has to start immediately when a suspicious patient is treated in a department. What the authors meant was that, in order to positively identify TB either positive culture or histological proof had to be obtained. In order to elucidate the misunderstanding we added the following phrase: “TB treatment is often started immediately after the appropriate microbiological and histological samples have been obtained if the clinical suspicion is high. TB, however, must be confirmed by positive culture or histologic proof.”

3. I don't think the ultrasound dimensions in the text or the reproduction of the ultrasound scans add anything to the report and would remove them. The ultrasound images are particularly difficult to interpret
   We agree in both comment and in that perspective we removed the appropriate elements from the case as well as the figure 2.
4. The CT scans and photograph of the patient are very good though. However it would be preferable just to use one CT image of a good size rather than four small ones. The comment is justified and therefore we replaced figure 2 with a CT image of good size.

5. The doses of rifampin and pyrazinamide are substantially lower than those recommended in WHO, USA or UK guidelines - suggest re-check the doses with the treating physician.

Indeed, the treating doctor (Dr. Paramythiotis) responsible for the pharmaceutical treatment was asked to re-check the doses that he initially gave to us for the report. He said that the exact doses employed were as follows: Isoniazid (300mg), Rifampin (600mg), Pyrazinamide (2g), and Pyridoxine (50mg). Appropriate corrections were made.

6. I assume the patient was tested for HIV and found to be HIV negative. I think it is important to state this specifically as TB is a very common presenting illness in HIV.

We fully agree with the above mentioned comment. HIV test were performed indeed and in order to state this, a phrase was added in the case report.

Phrase added: “HIV test was performed and gave negative results.”