Reviewer’s report

Title: Rapidly progressive form of Bronchiolitis Obliterans Organising Pneumonia presenting with pneumothorax, persistent and recurrent air-leak, acute respiratory distress syndrome and multi-organ dysfunction

Version: 3 Date: 3 October 2007

Reviewer: Max MAURIN

I am familiar with the literature and believe that this case meets one of the 7 criteria for evaluation in the journal: Unexpected or unusual presentations of a disease

Has the case been reported coherently?: No

Is the case report authentic?: Yes

Is this case worth reporting?: Yes

Is the case report persuasive?: No

Does the case report have explanatory value?: No

Does the case report have diagnostic value?: No

Will the case report make a difference to clinical practice?: No

Comments to authors:

General

The present manuscript describes a severe case of bronchiolitis obliterans organizing pneumonia (BOOP) in a 17 year-old patient, with unusual findings such as persistent air-leak, acute respiratory distress syndrome (ARDS), multi-organ dysfunction and myocardial infarction. Although the present case is very interesting, further information is needed.

BOOP is primarily defined by characteristic histological findings on lung biopsies, and several types of lesions have been described. It would be essential to better describe histological lesions found in the patient’s lung tissue.

Although BOOP is often an idiopathic disease, several etiologies have been characterized, including infectious diseases, rheumatologic or connective tissue diseases, organ transplantation, radiotherapy, and some drugs. It would be of interest to better describe the presence or absence of these favoring conditions in the reported case.
Several infectious disease agents have been associated with the occurrence of BOOP. These include bacteria (Chlamydia, Legionella, Mycoplasma, and Coxiella burnetii, the agent of Q fever), viruses (adenovirus, cytomegalovirus, influenza virus, HIV), protozoa (Plasmodium) and fungi (Pneumocystis). Most of these agents may not be detected by regular culture methods for blood, urine and BAL specimens. Diagnosis may only be established by specific non-culture methods. The authors should better describe which diagnostic methods were performed in their patient.

Likewise, although the authors stated that “serological testing for atypical pneumonia” was done, they should specify which etiological agents were search for. As an example, Q fever is often not included in “atypical pneumonia” investigations (Cf. Perez de Llano LA, Racamonde AV, Bande MJ, Piquer MO, Nieves FB, Feijoo AR. Bronchiolitis obliterans with organizing pneumonia associated with acute Coxiella burnetii infection. Respiration. 2001;68(4):425-7).

It’s very important to specify which antibiotics and antifungals were administrated to the patient, since specific infectious etiologies may not be covered by this treatment, and also because some drugs (e.g. amphotericin B, cephalosporins, minocycline) may cause BOOP.

Corticosteroids remain the mainstay in treatment of BOOP, usually with rapid clinical improvement. This is a main argument (with pathological investigation) for BOOP diagnosis in the present case. However, corticoid therapy should usually be prolonged for ~ one year to prevent relapses. It would be of interest to better describe clinical evolution in the patient, and how long was corticoid therapy administered.

Macrolides have been occasionally reported to be effective in BOOP patients, together with corticosteroids. Did the patient receive a macrolide antibiotic ?.

Revisions necessary for publication

What next?: Revise and resubmit

Quality of written English: Acceptable