Author's response to reviews

Title: Mediastinal pancreatic pseudocyst with isolated thoracic symptoms: a case report

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Dear Sir or Madam,

Please find attached the revised form of the manuscript "Mediastinal pancreatic pseudocyst with isolated thoracic symptoms: a case report." We have thoroughly gone over the critical referee's comments, and have endeavoured to hopefully adequately rectify the paper's stated shortcomings. Here are the comments to each reviewer.

Reviewer 1:

I think the title "Paracardial pancreatic pseudocyst... ...." is not appropriate. The location is in the mediastinum and term mediastinal should be used. "Mediastinal pancreatic pseudocyst..."

The title has been changed to "Mediastinal pancreatic pseudocyst with isolated thoracic symptoms: a case report."

In abstract: (page 2)
Case report: it is important to emphasize that the patient suffered from chronic pancreatitis.

We have added that the patient suffered from chronic pancreatitis in the abstract.

Conclusion: it is not true that in mediastinal pancreatic pseudocysts patient present with acute exacerbation of pancreatitis. (See references 3, 6, 7, 8 10 cited in this article as well as, Mohl W et al Endoscopy 2004:36:467.)
Generally pseudocysts in chronic pancreatitis most often are found in the absence of a recent attack of acute pancreatitis (acute on chronic). It is true that they may develop after an episode of acute attack but more often they appear...
insidiously.

The referee is right. We have corrected this in the conclusion section. In addition we have cited the suggested reference (Mohl et al 2004).

Case presentation (page 4). Case reports should include relevant positive and negative findings from history, examination and investigation. It would be wise to note the values of serum and urinary amilase as well as lipase if it was determined.

We have added relevant laboratory findings like serum amylase and lipase level in the case presentation.

Description of Fig 3. in text is incorrect. "....(MRCP) showed the cystic stricture with small contact area to the pancreatic tissue and a high-grade stenosis of the pancreatic duct with only moderate dilatation of the proximal duct (Figure3)." this figure shows dilatation of the distal pancreatic duct (part of the duct in the body and tail of the pancreas). It is wise to mention the size of this dilatation especially due to operation that was performed (pancreaticojejunosomy). The size of the pancreatic duct can be measured on transabdominal or endoscopic ultrasound (the later was conducted in this patient as well as ERCP.)

We corrected the description of figure 3 as suggested. In addition we mentioned the size of the pancreatic duct.

How did "a small intrapancreatic mass at the site of stenosis" suspected? (by endoscopic ultrasound or another diagnostic tool?) I think that this need an explanation.

The mass was suspected by endoscopic ultrasound and elastography. We have added this in the case report.

It will be interesting to see figure of CT scan performed 6 days after surgery. If the authors have that please ask them to present it.

The first submitted version of the report included more images, which were removed in the process because only three images are allowed.

DISCUSSION (page 6)
Authors should be asked to refer on literature correctly. It is incorrect that in reference 6 (Komtong et al JOP 2006;7:405-10.) was description of patient that have acute pancreatic inflamation. In this article (Komtpon et al.) authors deal
with posttraumatic pseudocyst without any history of acute attack of pancreatitis.
The referee is right. We have corrected this in the discussion section on page 6.
There is a small typing error in line 12 "dyspnea and dyspnea" I suppose that author meant dysphagia.
In line 12 (page 6) dyspnea was corrected to dysphagia.

It is unclear what type of surgery was performed. The authors mentioned external drainage of the cyst, the resection of the part of the pancreas and side to side pancreatojejunostomy.
From surgical point of view it is unclear what type of resection was done and when resection was done why they performed longitudinal pancreatojejunostomy. This part is unclear.
Part of the pancreas was resected because of the suspected malignancy; this has been added to the text. The kind of the anastomosis depended on the complicated local conditions due to the postinflammatory changes.

Reviewer 2

There are 3 errors in the text (DISCUSSION):
1. in the page 6, 1st paragraph and line 8: ¿in the ¿¿
2. in the page 6, 2d paragraph and line 3: ¿dyspnea and dysphagea¿¿
3. in the page 6, 2d paragraph and line 6: ¿of lipoma,¿.¿
All three minor errors have been corrected.

The authors must revised discussion section:
1. The order of the paragraph must adjusted. We suggest the following plan: pathophysiology, symptoms, diagnosis, management and conclusion.
We have critically gone over the discussion section and adjusted the paragraphs as suggested.

2. In the paragraph of management, the authors must detail the different therapeutic options reported in the literature other than the surgical one and we must focus on the different cases treated endoscopically with their references.
References were to go into more detail regarding this issues.
I sincerely hope that we have suitably taken your criticism into consideration, and
that you will find the alterations we have undertaken satisfactory so as to reconsider the paper for publication in the Journal of Medical Case Reports.

Yours sincerely,

Carsten Lukas