Author's response to reviews

Title: Mesenteric Panniculitis with pedal edema: A case report

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

Greetings,

The authors would like to thank the respected reviewers for their valuable comments. The manuscript has been revised in light of these comments. A point-by-point response to reviewers' comments follows.

Kindly keep us informed of the review/acceptance status of the article.

Best Regards,

Dr. Abdul Mueed Zafar

Aga Khan University,

Karachi, Pakistan
Reviewer's report A

Reviewer: Nereo Vettoretto

Comments to authors: Diagnosis is incomplete. Mesenteric panniculitis (as it seems the most reliable phase diagnosis in reading the description of the specimen) has to be diagnosed by the presence of fatty necrosis or fibrosis, foamy macrophages in the inflammatory infiltrate, after adequate immunohistochemistry. Clinical aspect, immunosuppressant therapy (achieving symptomatic relief) or CT scan appearance alone are not enough to exclude other pathologies which concur to differential diagnosis. In fact pedal oedema might suggest a quote of lymphostasis which might be due to retroperitoneal fibrosis, liposarcoma or even nodal interest by other haematological tumors. Another way to achieve diagnosis is to make a FNAB in the recurrent mass: has it been done? Since a second explorative laparotomy might seem too invasive at the time, is the mass still bulging or has it shrinked after immunosuppressive therapy? You do not describe any control scan, neither pre or post therapy.

Authors’ response: Histological findings were also considered in diagnosis. Although this was already mentioned in the case report, we have described histological findings in greater detail.

The respected reviewer has rightly mentioned the value of immunohistochemical tests and radiological follow up of the disease to establish the diagnosis. Our patient did not have the financial resources to afford these investigations. Since our health care system is privately funded. We agree that detailed diagnostics would have been of great value. However, the option was not financially viable in our case. The cost of one CT scan exceeded the patient’s monthly income. We had to resort to the minimum possible diagnostic investigations.
The association between pedal edema and mesenteric panniculitis has been discussed in greater detail. Development of chylous ascites secondary to mesenteric panniculitis has been reported in literature. We suspect that pedal edema may have developed by a similar mechanism.

**Comments to authors:** I do not agree with the usefulness of explorative laparotomy as it is described in literature to be the fundamental step in diagnosis. Too much enhancement on radiology alone might mislead, as histology is nowadays the only way to differential diagnosis. A work by Akram S and coll. from the Mayo Clinic in Rochester has been recently published and examines a large cohort of patients (Clin Gastroenterol Hepatol. 2007 May;5(5):589-96). To my advice it should be cited.

**Authors’ response:** We concur with the respected reviewer regarding the role of exploratory laparotomy in the diagnosis. We hope that a better understanding of this entity would decrease the number of exploratory laparotomies in such patients and would lead to progressively less invasive diagnostics.

We also thank the reviewer for suggesting a very pertinent reference. The citation has been included in the report.

**Comments to authors:** Quality of written English: Needs some language corrections before being published.

**Authors’ response:** Language and syntax have been revised.
Reviewer's report B

Reviewer: Angel Popkharitov

Comments to authors: The authors should describe more profoundly and accurately the surgical finding, the type of operation.

Authors’ response: The intra-operative findings have been described in greater detail. Please refer to the ‘case presentation’ section.

Comments to authors: There is not clear if frozen section procedure was performed.

Authors’ response: Frozen section was not performed during the procedure. Only an excision specimen was submitted to histological review.

Comments to authors: The histological findings are described insufficiently. There would be well if the authors apply an image on microscopic section, if any.

Authors’ response: Only the concluding excerpt from the histopathology report has been included to keep the case report succinct. The authors regret to inform that their access is limited to the histopathology report only.

Comments to authors: The authors concluded that the diagnosis of MP was made based on history, physical examination and the CT findings, but not on base of histological section. Therefore I think the title should be changed and related with the CT examination.

Authors’ response: The diagnosis was made retrospectively and histological findings were also taken into consideration. This point has now been described in case report with greater clarity.
Comments to authors: It is not clearly described “the pedal edema” and its relation with MP.

Authors’ response: Pedal edema was part of the initial presentation of the disease and resolved after immunosuppressive therapy. A discussion of its relation to MP has been added.

Comments to authors: A more thorough search in relevant literature would place the case report in a better context.

Authors’ response: We have revisited the pertinent literature. Five citations have been added.

Comments to authors: The written English needs some improvement. I suggest the authors to ask a native English speaker to check the case report for fluency.

Authors’ response: Language and syntax have been reviewed.