Author's response to reviews

Title: A Case Report of a 33 Year Old Female with Concomitant Sinus Histiocytosis with Massive Lymphadenopathy (Rosai-Dorfman Disease) and Diffuse Large B-Cell Lymphoma

Authors:

James C Moore (jmoore@frontrangecancer.com)
Xiaohui Zhao (zhaox@uci.edu)
Edward L. Nelson (enelson@uci.edu)

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Author's response to reviews: see over
Dear Dr. Kidd,

We appreciate the thoughtful reviews and constructive comments of the reviewers of our recently submitted manuscript entitled “Concomitant Sinus Histiocytosis with Massive Lymphadenopathy (Rosai-Dorfman Disease) and Diffuse Large B-Cell Lymphoma in a 33 Year Old Female.” We have carefully considered the comments of the reviewers and made the requested revisions. We made the requested revisions and will detail them below.

Reviewer #1 - Chris Bacon

1. The authors should provide further (but brief) details of the other known cases of SHML in patients with NHL, perhaps as a table. Such details should include the type of NHL in each case. This should be possible without exceeding the word limit and the relevant papers are already referenced.

We have included a new table, Table 1, with the requested information on the cases of SHML associated with NHL. In the course of compiling this table we identified that we had inadvertently failed to include the cases described by Focar et al (our reference #3) in the total reported cases of SHML associated with lymphoma. These cases are included in the table and we have revised the text accordingly to account for this recognition, Page 9. In Table 1, we have included (as requested) the histologic sub-type of NHL (if reported), the sites of NHL and SHML/RDD, and the time interval between establishing these two diagnoses. We agree that this enhances the manuscript and appreciate the request by Dr. Bacon.

2. A panel in Figure 2 showing the diffuse large B cell lymphoma should be included.

We have included a fourth panel for Figure 2, Panel D in which we show a representative photomicrograph of tumor mass tissue obtained at autopsy depicting the diffuse large B cell lymphoma and an insert showing the positive anti-CD20 staining, Figure 2 and Page 6.
1. The abstract should be shortened. The details should be left to the introduction and discussion.

We shortened the abstract by moving the details of the case and the disease entities to the body of the text as suggested. This resulted in the abstract decreasing in size from 335 to 273 words. This of course was accompanied by a slight increase in body text size from 1773 to 1865 words, Pages 2 and 3.

2. In the case report section: the sentence: "significant sweating at night that did not reach the threshold for classic night sweats" should be replaced simply by “mild night sweats”.

We revised this section to incorporate the phrase “mild night sweats” as requested. Because we hold the view that the description of classic “night sweats” requires sufficient sweating to necessitate the changing of bedclothes or bed sheets, we respectfully retained this description as a qualifier for the term “mild night sweats.” In this case, the standard for classical night sweats was not met, thus, we respectfully consider the term “mild night sweats” to be somewhat ambiguous if present without the qualifying statement, Page 4

3. In the case report: The following sentences should be deleted: “A chest radiograph suggested splenomegaly and an abdominal ultrasound revealed extensive adenopathy in the periaortic region with a more prominent hypoechoic mass at the left renal pelvis. A report of an abdominal ultrasound performed five months earlier at a separate facility was reported as being negative for pathologic findings.”

This section was extensively revised, deleting the discussion of the chest radiograph. We retained the discussion of the ultrasound study, as this was the first identification of abdominal lymphadenopathy that was not identified in a comparable study performed five months earlier. We feel that this provides a measure of the pace of development of the pathologic process and thus is informative for the patient’s clinical course, Page 4

4. In the case report: The following sentence: “In the chest, there were three lymph nodes in the aortopulmonary window and pretracheal areas measuring 6 to 8 mm and one larger lymph node in the azygoesophageal recess, Figure 1 Panel A”: Please describe only the large lymph node (the one measured in figure 1 panel A) and please dismiss the 6 and 8 mm nodes.

As requested, we deleted the description of the smaller lymph nodes identified on the Chest CT scan. The size of the largest lymph node was added to the description, Page 4.

5. In the case report, please mention how the excisional biopsy was done: by laparoscopy? By laparotomy? By CT guided biopsy? Please provide the macroscopic size of the excisional biopsy.

We revised the description of the initial biopsy procedure including a notation that the biopsy was performed by laparoscopy and including the sizes of the three lymph nodes excised for the initial biopsy. Page 5

6. In the case report: “Some histiocytes contained lymphocytes in their cytoplasm (emperipolesis)”. Please mark with an arrow “emperipolesis” on Figure 2 Panel B.
We added arrows to Figure 2, Panel B. Grey arrows designate single lymphocytes within histiocytes. Black arrows bracket a series of five lymphocytes aligned in a curvilinear manner in a field of histiocytes. These designations are provided as examples of emperipolesis, text changes on Page 5

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Please extend our appreciation to the editors and expert reviewers for their attention and consideration of our revisions.

Sincerely,

Edward Nelson, M.D.

Enc.
cc: Primary and co-authors