Author's response to reviews

Title: Breast pseudotumoral radionecrosis as a late radiation induced injury: a case report

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Version: 6 Date: 11 January 2009

Author's response to reviews: see over
Dear Professor Dartevelle

Thank You for the second revision of the manuscript. Please see our comments below.

H. Gerullis

Reviewer 1: Philippe PD Dartevelle

1. The manuscript did not highlight the main interests of the report (pseudotumoral aspect, therapeutic options).

In our opinion the case report in its present form highlights the pseudotumoral aspect of the tumor as well as therapeutic options. The mentioned points are extensively described in the manuscript.

a) Pseudotumoral aspect of the tumor was described in the text including a clinical description and an extensive description of the histological findings. In addition various figures are provided to underline the characteristics of the tumor, including both macroscopic and microscopic aspects.

b) Therapeutic options as surgical resection or conservative strategies (see text) are described and discussed, pathophysiological correlations are named. The intention of this case report was to describe this interesting case of a late radiation induced injury as an important differential diagnosis after initial anti cancer treatment. We reported our surgical approach/results and discussed it with regard to other, especially conservative, treatment options.

In conclusion, we think that this manuscript highlights the main interest of the report (pseudotumoral aspect, therapeutic options).

We are very greatful to both reviewers, which evaluated the manuscipt from different standpoints due to their outstanding, particular scientific and clinical expertise. However, there will always remain scope for additional information or discussion. Within the limited word count provided we described the case as extensively as possible providing numerous figures in order to visualize as much information as possible and in order to discuss the case from both, conservative and surgical points of view.
2. You did not focus the report on the difficulties to make the diagnosis of pseudotumoral radionecrosis and on the surgical strategy. The point is how to diagnose and how to treat chest wall radionecrosis.

The reviewer is right, definitive preoperative diagnosis is difficult to achieve in comparable cases. However we extended the preoperative diagnostic tools as described in the case presentation. In summary our preoperative work up could decrease the suspicion of a malignant process which, postoperatively, could be confirmed by histology. Our surgical approach was independent from histology of the tumor since local limitation could be assumed as described and supported by the figures provided in the text (Figure 2 e.g). In summary the surgical approach should be to resect the maximum of the tumor tissue providing the highest quality of life as was intented in this case and as was extensively described and discussed in the case report.

In addition, besides radiological diagnostic possibilities we provided information regarding preoperative tools as LENT-SOMA scale in order to measure progress of late radiation induced injuries which include chest wall necrosis.

Treatment includes surgical and conservative options as tocopherol etc. as already described in the discussion and conclusion section.

3. The introduction did not tell us why this clinical report could be useful to our clinical practice.

The introduction has been modified.

4. Did you use an ipsilateral or controlateral latissimus dorsi flap? Was there any difference?

We used an ipsilateral latissimus dorsi flap. We did not see any difference. (modified in the manuscript)

5. Why didn’t you perform a biopsy of the « pseudo-tumor » before surgery?
Diagnostic work up (bone scintigraphy, abdominal ultrasound, thoracic CT-scan) revealed no local or distant metastases as shown in Figure 2, there was no radiological suspicion for a systemic malignant process. Thus we concluded that the tumor was locally defined. Since the surgical procedure focussed on the resection of the tumor we did not see the necessity of a preoperative biopsy which would not have changed the procedure. However, the patient signed a consent that in case of malignancy the surgical procedure could have been extendend including all necessary conversions in order to resect the focal tumor. (modified in the manuscript)

6. Although, the last chest tube had been removed at day 8, the patient was discharged at day 18. What did happen between day 8 and day 18?

After removal of the second chest tube the patient complained about continous minimally decreased chest pain as described in Case presentation. We offered the patient to stay as long as required in order to optimize the analgetic therapy. Thus, she decided to stay until day 18 although from a clinical point of view the discharge would have been possible earlier in the course. Except the prolonged postoperative pain there were no particular adverse events that required the extended hospital stay.