Author’s response to reviews

Title: Tuberculous disseminated lymphadenopathy in an immunocompetent, non-HIV man: a case report

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Author’s response to reviews:

Dear Editor

We appreciate your further evaluation of our manuscript. We believe that your comments were accurate and we feel that we should correct our manuscript according to your suggestions. Our responses to your comments are provided hereafter. For your facilitation we provide your comment prior to each of our responses. All changes in the original have been provided in red text.

We are at your disposal for any further clarifications or corrections.

Yours sincerely,

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REFEREE 1

The authors seek to review diffuse tuberculous adenopathy in a non-HIV, immune-competent individual. This is an important differential to remember. However, I would suggest the following:

1) The authors note that "In disseminated lymphadenopathy, the differential diagnosis has to include both benign and malignant causes including sarcoidosis, metastases, lymphoma, or rarely, tuberculosis." This is mentioned in the abstract, the introduction, the discussion, and the conclusion. I would mention it once and delete the others or at the very least, change the wording.
Rephrasing was done in most cases as suggested.

2) In the discussion, the authors review the course of TB in patients with HIV/AIDS. This has no relevance to this case so I would delete it.

More details about tuberculosis in HIV infected patients in discussion were excluded as suggested.

3) In the discussion, the authors describe the physical findings of tuberculous adenopathy. It would be helpful to compare and contrast those findings with those of the other major syndromes in the differential (sarcoid, metastases, lymphoma).

Hard, fixed nodes are found in cancers and firm, rubbery nodes are found in lymphomas. These physical findings are added in page 7 paragraph 2.

4) The authors do not describe the overall success of medical therapy and the time course of resolution of symptoms. If data is available, this should be cited.

After 2 months of treatment, he was symptom-free, with a prominent reduction in most lymph nodes swelling and the patient was started on a two-drug regimen of isoniazid and rifampin for 7 months. At the end of the therapy, the patient had residual lymph nodes in the neck and in the mediastinum.

This is added in the text page 5 paragraph 3.

5) At the end of the discussion, the authors note that“ aspiration or incision and drainage of fluctuant nodes is beneficial”. I would cite the data for that. I am not sure that this is a generally accepted intervention. En-bloc excision has been described however and probably should be mentioned.

It seems that it was our misunderstanding of the literature. So, an excisional biopsy is preferred, since an incisional biopsy may result in sinus tract formation and this is suggested mainly for diagnostic purposes.

6) While not necessary, it would be helpful if the authors reviewed the physical exam presentations of the other major possible clinical entities to see if the differential can be narrowed by physical exam or simple tests.

Constitutional symptoms such as fever, night sweats, or weight loss suggest tuberculosis, lymphoma, or other malignancy. Associated splenomegaly suggests lymphoma but in our case the patient had splenomegaly. Probably, it seems that in most cases , the physical exam presentations cannot help the diagnosis of generalized lymphadenopathy and the definitive diagnosis of TB lymphadenitis is made by histology and culture of lymph node material.
Quality of written English: Needs some language corrections before being published

Language corrections were done as suggested.

Declaration of competing interests:

None of the authors has any competing interests.

REFEREE 2

1. The case presentation needs some organization. I think there is some information that can be eliminated as it is not important to the salient features of the case. These include the history of schizophrenia and the treatment of the condition, and some of the laboratory data. The authors should also re-organize the presentation. For example, the first paragraph has some history, then physical examination, and then back to some history. Describe the history, give vital signs and exam to include description of lymphadenopathy, and then go on the laboratory and diagnostic studies.

Changes have been done as suggested. The case presentation was better organized and the history of schizophrenia was eliminated.

2. In the case presentation, the patient is reported to be obtunded. Was cerebrospinal fluid obtained for analysis to determine whether the patient had tuberculous meningitis?

Cerebrospinal fluid (CSF) was obtained for examination which revealed no cells and its biochemical composition was normal. This is added in the text, page 4 paragraph 2.

3. In the case presentation describing the figures, indicate the figure numbers directly in the text.

Figure numbers were added in the text.

4. In the discussion, I would remove the information about tuberculosis in HIV infected patients, as the point of this case is that the patient is immunocompetent.

Most details about tuberculosis in HIV infected patients in the discussion were excluded as suggested.

5. In the discussion, the authors discuss aspiration and drainage of lymph nodes. My understanding of the literature is that complete excision of involved nodes
with no drains is usually recommended to diminish the possibility of postoperative fistula formation.

We agree with the reviewer's comment that an excisional biopsy is preferred, since an incisional biopsy may result in sinus tract formation and this is suggested mainly for diagnostic purposes.

6. In reference #6, the specific author who wrote the tuberculosis chapter should be included in the citation, along with page numbers. They were added in the references.

7. Please add arrows to the figures to elucidate what is being described in the figure legends. Arrows were added in the figures.