Author's response to reviews

Title: Pseudoinfarction pattern in a patient with hyperkalemia, diabetic ketoacidosis, and normal coronary vessels: a case report

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M. Kidd
Editor in Chief,
Journal of Medical Case Reports

Dear Sir:

We would like to submit the revised case report “Pseudoinfarction pattern in a patient with hyperkalemia, diabetic ketoacidosis, and normal coronary vessels: a case report” in your journal.

We have made all the necessary changes according to the reviewers’ comments.

Reviewer 1, comment 1: we fully understand the reviewer’s comment. Apart from treatment with intravenous insulin, and sodium bicarbonate which was already mentioned in the submitted case report, the patient was also administered calcium gluconate.

For this reason, we mention now in the second paragraph of the case presentation of the revised case report: “The patient was initially treated with fluid replacement with normal saline, intravenous insulin at 7 units/hour, sodium bicarbonate, calcium gluconate, aspirin, clopidogrel, and low molecular weight heparin.”

Reviewer 1, comment 2: We understand the reviewer’s comment that angiography was performed before complete correction of the metabolic
abnormalities. However, as we mention in the second paragraph of the case presentation, in our case “we performed coronary angiography in order to exclude an anterior acute myocardial infarction, which could lead to severe myocardial damage and possible severe complications (heart failure etc.), if there was treatment delay.” For this reason angiography was performed before complete correction of the metabolic abnormalities.

Reviewer 1, comment 3: We have changed his into her in the last paragraph of the case presentation.

Reviewer 2, comment 1: we fully understand the reviewer’s comment. CK, and CK-MB values were measured on admission, and in the second sample and were normal. Troponin I concentration was also measured in the same time intervals and was normal. We only mention in the manuscript troponin I concentration, as it is considered more specific and accurate for the detection of myocardial damage-necrosis. As the patient presented to the hospital 4 hours after the epigastric pain started, and troponin I concentration can be normal at that time, we didn’t mention this value in the submitted case. We only mentioned in the last paragraph of the case presentation that “Her troponin I concentration 12 hours after admission was normal (0.1 µg/l)”. We have added now in the revised case report that: “Biochemical results showed the following serum concentrations: potassium 7.2 mEq/L, sodium 127 mEq/L, urea 97 mg/dl, creatinine 2.26 mg/dl, glucose 676 mg/dl, and normal troponin I concentration (0.1 µg/l).”

Regarding acidosis, this had partially but not completely resolved in the second blood sample. Acidosis resolved completely after 24 hours. We have not mentioned anything about the serial measurements of PH in our case, but we are ready to do so if it is considered necessary.

Once again we would like to mention that we are readily prepared to make any further changes needed, which would increase the likelihood of publication of our manuscript in your journal.

Yours truly,

Antonios Ziakas, M.D., PhD, FESC.