Author's response to reviews

Title: Benign Cystic Mesothelioma of the Appendix

Authors:

    Donal brendan 0' connor (donaloconor@yahoo.com)
    David Beddy (davbeddy@rcsi.ie)
    Muyiwa A aremu (maremu@rcsi.ie)

Version: 2 Date: 26 August 2010

Author's response to reviews: see over
Dear Editorial team,

We would like to thank both reviewers for their detailed comments. We have used their criticisms to improve the manuscript. It has been revised accordingly and the specific concerns are answered below. (In bold italics)

Yours sincerely,
Donal O’ Connor

Reviewer's report

Title: Benign Cystic Mesothelioma of the Appendix

Version: 1 Date: 15 February 2010

Reviewer: omar Duenas

Comments to authors:

I enjoyed reviewing the article with the title of "Benign Cystic Mesothelioma of the Appendix"

1. the article needs some special attention in the redaction and the grammar of the article to look more professional.

The language, grammar and nomenclature have been improved in the manuscript.

2. One of the differential diagnosys in a woman of this age and a pelvic mass and labile fever could be a tuboovarian abcess and the authors never mentioned if they did cultures. or at least I think it should be mention in the discussion.

This is an excellent point. Clinically this was considered but we failed to include it in the original submission. This is included in the revised manuscript as tubo-ovarian abscess is an important differential for our patients' clinical presentation. Blood and aspirate cultures were sent.

3. The article reports a benign cytic mesothelioma, that it is a rare entity but it soley reason that is "rare" is not the only reason to be published, think that with some modifications making more emphasys to the differential diagnosys and that the diagnosys of this disease is basically by exclusion or as a finding while
surgical excision.

_The manuscript has been altered to place the importance of including BCM in the differential of pelvic masses in females of reproductive age especially and highlight how it presents._

4. My recommendation is to accept the article with the pertinent modifications in the grammar and the previous observations that I previously described.

Quality of written English: Needs some language corrections before being published

_We believe the quality of English and style of the manuscript has now been improved._

Reviewer's report

Title: Benign Cystic Mesothelioma of the Appendix

Version: 1 Date: 3 February 2010

Reviewer: Wolfram Trudo Knoefel

Comments to authors:

General:

This manuscript contains an interesting case but I do have some concerns:

1. Why was an interventional drainage performed? The cystic lesion is not a 'proof' of an appendicitis.

_We agree that the CT appearance does not prove appendicitis but the clinical picture (pain, fever) and that the mass was to include the tip of the appendix on CT made an appendix abscess or a tubo-ovarian abscess a strong possibility. U/S guided drainage was agreed to be an appropriate and safe next step after consultation between radiology and several surgeons. This has now been clarified in the manuscript._

2. The serous drainage is suggestive of another diagnosis than appendicitis!

_Good point. We agree. Also the fluid grew nothing on culture. Therefore we arranged an interval laparoscopy keeping an open mind that there may be other pathology eg ovarian or caecal. If however a resolving appendicitis was found and no further pathology see, an interval appendicectomy could be performed at that time. This has been clarified in the manuscript._

3. How would the authors differentiate the lesion from a mucinous cystadenoma (Krieg et al. J Med Case Reports. 2008;2:218.)
We don’t believe it could be differentiated from a benign or malignant mass eg mucinous cystadenoma or adenocarcinoma or lymphangioma based on appearance at laparoscopy or by imaging. For fear of rupturing and seeding a possible malignant mass we converted to a right iliac fossa incision.

4. Why would the authors attempt to treat this lesion by laparoscopy in a young female patient when a local approach yields much better cosmetic results?

We were not sure what the pathology was so a diagnostic laparoscopy seemed a reasonable approach and if the appendix appeared to be the source of the mass/resolving it could be removed laparoscopically with very good cosmetic results in a young female. The patient had settled clinically so we were confident to be able to successfully perform an appendicectomy laparoscopically. At laparoscopy however, the cysts arising from the appendix were so friable we were concerned we would rupture them so we converted to a skin crease incision in the right iliac fossa.

5. The note that the specimen ruptured during transfer from the OR table to the photography table is not convincing.

I only mention it to illustrate how friable it was to illustrate why we feared rupturing in situ as we did not know if it was benign or malignant.

6. What precautions did the authors take to prevent recurrence after ‘accidental’ drainage?

The original drain puncture site had been made in the right iliac fossa and this was incorporated into the operative incision. The patient has been followed clinically and had a normal ultrasound at 6 months.

7.

The non-in-toto specimen has poor educational value.

We believe it illustrates the size and that multiloculated cysts were attached to the larger, thick walled cyst in continuity with the tip of the appendix. If only I had not ruptured it the picture would be more useful.

8. What is new about this particular case to make it of value to the reader?

It highlights a rare cause of pelvis mass to be included in the differential for abdominopelvic pain/masses particularly in females of reproductive age. It also highlights the difficulty sometimes in diagnosing pelvic masses despite imaging and the confusion caused by the simultaneous presentation of acute appendicitis as this is the first case of BCM arising from an inflamed appendix.

Minor:
1. The authors requested CT scan of the abdomen for this young patient which means radiation exposure. What about ultrasound?

Thank you for this point. We do not like to use CT in young females but an ultrasound was inconclusive and only raised suspicion of a mass and CT was recommended by radiology for further evaluation to rule out a tumour (which it was not able to do!) or guide drainage if the mass was an appendix or tubo-ovarian abscess as seemed likely clinically. An MRI might have been preferable in hindsight.

2. The references should be listed adequately with title and full citations in a coherent way

The references have been corrected appropriately.

Quality of written English: Acceptable