Author’s response to reviews

Title: Bromocriptine treatment is associated with recovery from peripartum cardiomyopathy in siblings: Two case reports

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Author’s response to reviews:

Dear Editor

Please find enclosed our revised manuscript entitled “Bromocriptine treatment is associated with recovery from peripartum cardiomyopathy in siblings: Two case reports”.

We have carefully addressed all points raised by the reviewers and have submitted this revision already in June 2009. Upon revision (the response to the reviewer is attached again) it was accepted and we obtained proofs. Unfortunately the handling editor had sent out the initial version and not the revised version for manuscript preparation. We informed him (Richard Sears) and submitted the revised version again directly to him.

This is a never-ending story which is very frustrating (especially for the students who also contributed to this work). I truly hope that this is now the final stage of the manuscript.

Sincerely, yours

Denise Hilfiker

Rebuttal JM 6181

We thank the reviewer for her/his thoughtful comments.

1. The duration of heparin therapy is not stated
2. Did the authors convert heparin to warfarin?
3. The type (low molecular weight or unfractionated) of heparin is
4. The dosing and definition of "low dose" heparin is also not specified.

We apologize for not providing this information initially. In the revised manuscript we added the duration, the type of heparin, and the dose of heparin given to each patient as indicated in the text and below.

Case 1

Line 6: Therefore the patient was treated with the low-molecular-weight heparin (LMWH) Enoxaparin in a therapeutic dose (0,1ml/10kg KG) and subsequently switched to Coumadin (target INR 2.5).

Line 17: Heart failure therapy plus Coumadin for 6 months and Bromocriptine (2.5mg/d) for 6 weeks was continued.

Case 2

Standard heart failure therapy, half-therapeutic dose of Enoxaparin for 8 weeks (0,4ml/d) and Bromocriptine (initial: 5mg/d for 2 weeks and subsequent 2,5 mg/d) for 6 weeks) were initiated.

Discussion

Line 7: Upon initiation of standard therapy for heart failure together with heparin/Coumadin and Bromocriptine...

5. The conclusion discusses the possible genetic predisposition with no discussion on LV thrombus and bromocriptine therapy as the title suggest.

We rewrote the conclusion in the revised manuscript discussion bromocriptine therapy in conjunctions in the presence of a LV thrombus.

Discussion

While the risk for ventricular thrombi in PPCM seems more associated with the degree of cardiac dysfunction, the observation that Bromocriptine was effective in both patients points to a similar pathophysiology of the disease in the 2 sisters. The higher incidence of PPCM in women with African ancestry suggests the presence of genetic risk factors. However, reports on PPCM with positive family history are rare (1). Here we report PPCM in two sisters whose parents, a Caucasian mother (with no history of PPCM) and an African father suggest a possible genetic predisposition due to African ancestry.

Conclusion

The present case report suggests that Bromocriptine with appropriate anti-thrombotic therapy is safe and beneficial even in PPCM patients with manifested thrombosis at baseline. Furthermore, the development of PPCM in 2
sisters suggest that women with a positive history of PPCM might be at a higher risk for developing the disease and therefore, if pregnant, should be monitored carefully for cardiac abnormalities during pregnancy and peripartum.