Author's response to reviews

Title: EBV Myelitis and Castleman's Disease in a Patient with Acquired Immune Deficiency Syndrome (AIDS): a Case Report

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Author's response to reviews: see over
To The Editorial Team  
Journal of Medical Case Reports  

Dear Dr. Kidd,  

Thank you for considering our manuscript for publication in your journal. We appreciate the referees’ thoughtful comments. Below are our responses:  

To Reviewer 1:  
The figure shows HHV8 stain only  

To Reviewer 2:  
Antiretroviral medications were started in 2004, when patient had a CD4 nadir of 4, and it increased slowly. The HIV viral load had been undetectable for almost 4 years until presentation of MCD. Only one value of CRP was obtained and that was after he was given dexamethasone for treatment of his urinary retention. It is possible that steroids may have affected the value. As we don’t have a value when he was first diagnosed with MCD, we’ll remove the CRP value to avoid confusion.  

Figure 2 represents IHC for HHV8  

CNS lymphoma was excluded as cytology and the flow cytometry were not consistent with lymphoma. EBV PCR quantitative titer was not done only qualitative.  

Follow up of patient: The major complication he had group G strepococcal endocarditis with septic emboli to the brain that he survived.
We referred to the clinical trial that the patient was treated on using clinicalTrials.gov identifier: NCT00099073.

Bestawros A, Boulassel MR, Michel RP, Routy JP. J Clin Virol. 2008 Jun;42(2):179-81 reference was added (appreciate the input)

To Reviewer 3:

We updated our references to be up to date with the most recent review article on MCD.

We changed azidothymidine and replaced it with zidovudine. We changed all Castleman’s disease (CD) to Multicentric Castleman’s disease (MCD). Regarding CRP, as above. All references for HIV viral load, copies/mL. Figure 2, as above

To Reviewer 4

The pathologist’s complete evaluation.

PLASMABLASTIC MICROLYMPHOMA IN ASSOCIATION WITH MULTICENTRIC CASTLEMAN DISEASE

COMMENT:
Histologic section show enlarged lymph node with marked plasma cell infiltrate and a few paracortical foci of vascular spindle cell proliferation characteristic of Kaposi’s sarcoma. Follicles are variable in appearance from marked follicular hyperplasia to involution and dendritic cell hyperplasia. Several microscopic nodules composed of plasmablasts are noted within follicle centers and mantle zone. Immunohistochemical studies demonstrate lambda monotypic HSV8+/EBER+/BOB-1+/CD20-/CD3-/CD138- plasmablastic foci associated with intense polytypic plasma cell infiltrate. These findings are consistent with plasmablastic microlymphoma in association with Multicentric Castelman Disease (MCD, plasma cell variant).

IMMUNOHISTOCHEMISTRY RESULTS
Date submitted: 9/10/08 (BLOCK) A1

ANTIBODY RESULTS
CD3 (+) T cells
CD20 (+) B-cells
PAX-5 (+) B-cells
BOB-1 (+) B-cells, plasma cells, plasmablasts
KAPPA-ISH (+) plasma cells
LAMBDA-ISH (+) plasma cells, plasmablasts
CD21 (+) FDC
CD138 (+) plasma cells
EBER Negative
HSV8 (+) plasmablasts,

ANALYSIS: Paraffin sections are analyzed by immunohistochemistry. Known positive tissues are tested with each antibody and examined to ensure positivity. INTERPRETATION: This staining pattern is supportive of the above diagnosis.

To Reviewer 5:

We could find only one article of polyneuritis and Castleman’s (1983 a Spanish article), so we can say that polyneuritis is a rare presentation in Castleman’s. Since there was no Castleman’s in the CSF, it is unlikely that Castleman’s as cause of the myelitis. We believe it was the steroids that helped the patient’s symptoms, treatment that is for EBV related myelitis. Even though EBV presence by PCR may not be exclusively diagnostic, however EBV myelitis given the characteristic appearance of the MRI, is the most likely diagnosis in our patient.