Reviewer’s report

Title: Immune reconstitution inflammatory syndrome (IRIS) associated with Acquired Immuno Deficiency Syndrome (AIDS) related gastrointestinal limited Kaposi’s sarcoma presenting as Acute intestinal obstruction: A Case report & Literature review

Version: 2 Date: 28 June 2010

Reviewer: Jeff Martin

Which of the following following best describes what type of case report this is?: An unexpected event in the course of observing or treating a patient

Has the case been reported coherently?: Yes

Is the case report authentic?: Yes

Is the case report ethical?: Yes

Is there any missing information that you think must be added before publication?: Yes

Is this case worth reporting?: Yes

Is the case report persuasive?: No

Does the case report have explanatory value?: Yes

Does the case report have diagnostic value?: No

Will the case report make a difference to clinical practice?: Yes

Is the anonymity of the patient protected?: Yes

Comments to authors:

There are two issues that need additional data or discussion.

The first issue is whether the lesions are truly KS. The purplish lesions on the serosal surface of the small bowel look like KS, but they themselves do not appear to be responsible for the symptoms. Importantly, the “rounded cystic lesions containing dirty white fluids” in the mesentery are not, to my knowledge, typical for KS. Neither are the present of the prominent veins over the surface of these cystic lesions. This is relevant because KS is distinctly unusual in India. In fact, it is so uncommon that it has been hypothesized that Asian Indians may indeed have some protective factor against the development of KS. To resolve
this issue, at a minimum, the lesion should examined for the presence of human herpesvirus 8 latency-associated nuclear antigen (LANA). A commercial stain is available for this. The lesions should also be stained for mycobacteria and fungi. In addition, would recommend that the lesion photomicrograph be examined by an experienced dermatopathologist from a center with a high volume of KS. There are several such dermatopathologists at UCSF, for example.

The second issue is that if we assume the lesion is KS, then the question is whether it represents IRIS. It is not the case that any clinical event that occurs in the first 12 weeks after ART initiation represents IRIS. Instead, the finding may simply represent the natural progression of KS. In this case, we really cannot tell if KS in the gastrointestinal tract was present prior to ART. Specifically, we really cannot tell if the cystic lesion was present; it was not seen on the ultrasound either prior to ART or after symptoms had started. The only objective description of this case is that it might be IRIS or it might be simply natural progression of KS. It should not be described unequivocally as IRIS. If this patient has KS, the case should simply be described as an unusual manifestation of KS shortly after ART initiation.

A related issue is exactly how did the lesions cause abdominal obstruction? When I first read the abstract, I was expecting an intraluminal obstruction. Instead, the authors appear to imply that adhesions caused the obstruction. However, how were the cystic lesions related to the adhesions? Did the adhesions directly overly the cystic lesions?

Lastly, several typographical and grammatical errors should be repaired prior to any publication.

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

**Declaration of competing interests**: I declare that I have no competing interests