Author’s response to reviews

Title: Primary pleural leiomyosarcoma with rapid progression and fatal outcomes: a case report

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Version: 3 Date: 2 February 2012

Author’s response to reviews: see over
Reviewer: Angeliki Rapti

Dear reviewer

Thank you for the interest you brought for the revision of the manuscript. Your comments were very interesting and we took into account all your suggestions.

1- I agree with you, the symptoms and the tumor are located in the right sided. This is an error in writing and we are sorry to doing it

2- you' re right, but we have not detailed correctly all the exams made to eliminate the primary site. In fact, a gastric endoscopy was performed just before the diagnosis because the patient presented a gastroesophageal reflux. Both endoscopy and biopsies were normal. We failed to mention these symptoms because we think it is irrelevant to the tumor.

The patient didn’t show any other gastrointestinal symptoms and a colonoscopy was not performed. In our review of the literature, a gastric and coloscopic endoscopy were not performed systematically in the absence of digestive symptoms. The primary site was eliminated by a thoraco abdomino pelvic scan. PET scanner was used in only one case, but unfortunately this exam was not available in our country at the time of diagnosis

Reviewer: Georgios Stathopoulos

Dear reviewer

Thank you for the interest you brought for the revision of the manuscript. Your comments were very interesting and we took into account all your suggestions.

1- I agree with you, the symptoms and the tumor are located in the right sided. This is an error in writing and we are sorry to doing it

2- In fact the major differential diagnosis in this case was mesothelioma; that’s why we conducted an exhaustive immunochemestrical panel to eliminate it, we'll try to explain it better in the case observation.

   In addition, we will add the negative immunoreactivity images for more precisions.

3- We have added in the case presentation, more information about the pleural fluid
“Pleural fluid was serosanguineous. The biochemical analysis revealed that the nucleated cell count was 7800/mm³ (23% neutrophils, 71% lymphocytes); total protein concentration, 32 g/dl (a pleural fluid to serum ratio 0.52); lactate dehydrogenase level, 460 IU/l and glucose level, 110 mg/dl. The pH of pleural fluid was 7.30. These findings were consistent with exudative pleural effusion. Pleural fluid cytology was negative for malignant cells. The pleural fluid was cultured for bacteria (aerobic and anaerobic), fungi, and mycobacteria, and the results were negative.”

4- Language editing of the text was performed

5- I agree with you that the biopsy should be widely representative to allow a large immunohistochemical staining. In our case the fine needle biopsy was sufficient for immunochemistry that eliminated the other probable histological types. We discussed again the case with pathologists, radiologists, and thoracic surgeon, the diagnosis of pleural leiomyosarcoma was retained because of the absence of other location and the histological and immunohistochemical markers were in favor of primary leiomyosarcoma of the pleura

6- This case is particular, because the mode of initial presentation, represented by pleural effusion makes diagnosis more difficult. I would like to remind you the high incidence of tuberculosis in Morocco which makes it the first discussed diagnosis of pleural effusions. This may cause delays in diagnosis and treatment in neoplastic context. In addition, Mesothelioma is extremely rare in our country, and clinicians do not consider the diagnosis of cancer, in case of pleural thickening without associated lung injury. Subsequently our purpose was to raise awareness amongst clinicians adding this clinical entity as a differential diagnosis when a pleural mass is identified.