Author's response to reviews

Title: Hepatic tuberculosis presenting with extremely high serum ferritin masquerading as Adult onset Still's disease: A Case report

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Version: 4 Date: 9 March 2012

Author's response to reviews: see over
Author's response to the reviews (1 & 2).

Title: Hepatic tuberculosis presenting with extremely high serum ferritin misdiagnosed as Adult onset Still's disease - A Case report

(MS ID: 2146290045654550)

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Version: 4 Date: 9 March 2012

Author's response to reviews: see over (1 & 2)
Reviewer’s report (1)

Title: Hepatic tuberculosis presenting with extremely high serum ferritin misdiagnosed as Adult onset Still's disease - A Case report

Version 3 Date: 3 March 2012

Reviewer: Teresa Ferrari

Reviewer’s report:

2) Revisions necessary for publication:

To prevent readers from getting the idea that fulfillment of the Yamaguchi’s criteria is sufficient by itself to establish the diagnosis of adult onset Still’s disease, the authors should emphasize in the discussion (3rd paragraph of the section Discussion) that it is important to exclude the presence of other entities (infections, malignancies, rheumatic diseases and certain drug reactions) that can mimic Still’s disease and even meet the Yamaguchi’s criteria.

- Included.

3) Minor questions for publication:

A. How the authors explained the very high respiratory rate (46/min) at admission?
Patient had high fever on admission with severe malaise might affect the breathing. In addition patient was moderately pale with hemoglobin of 8.7g/L which would contribute to the dyspnea on admission. He had evidence of evolving disseminated intravascular coagulation (thrombocytopenia and deranged clotting functions) adding on to the multi-organ dysfunction on admission. Furthermore marked right hypochondrial pain and tenderness due to hepatomegally and elevated right hemidiaphragm would also have compromised the effort of breathing. However as the retrospective analysis suggests, sepsis contributing to dyspnoea cannot be excluded.

B. The reader is left wondering whether autopsy was performed.

Unfortunately, the relatives of the patient didn’t consent to perform an autopsy.

4) Minor issues not for publication:

A. The patient’s activated partial thromboplastin time (aPTT or PTT) and the prothrombin (PT), in seconds, should be reported along with the PTT and PT obtained from control (normal) plasma. Alternatively, PT may be expressed as the International Normalized Ratio or INR.

- Corrected

B. The authors should provide the upper normal value of the hepatic enzymes.

- Included
C. The anonymity of the patient is protected, but I think the stripe that covers the patient's eyes should be slightly larger.
- Done

D. Figure 2 - chest X-rays - seems unnecessary.
- Removed

E. The abbreviation PUO must be placed in full in the footnote of the table.
- Corrected

F. The references need to be standardized (especially titles of journals).
- Corrections done

Reviewer's report (2)

Title : Hepatic tuberculosis presenting with extremely high serum ferritin misdiagnosed as Adult onset Still's disease - A Case report

Version 3 Date: 8 March 2012

Reviewer: Ian Clifton

Reviewer's report:

1. Ensure "adult onset still's disease" is capitalised throughout consistently.
2. Ensure "mycobacterium tuberculosis" should be "Mycobacterium tuberculosis" and italicised throughout consistently. After first use should then be "M.tuberculosis" in italics.

3. Abstract line: 7 - "Sri Lankan man admitted" - "Sri Lankan man was admitted".

4. Abstract line: 10 - "Lab investigations" - "Laboratory investigations".

5. Abstract line: 13 - "Patient died" - "The patient died".

6. Case presentation: line 11 - "He was a teetotaler and a non smoker." - would suggest "He did not consume alcohol and was a non-smoker".

7. Discussion: "However extremely high levels (> 10000ng/ml) which is considered even as a marker in the diagnosis of AOSD, were rarely reported [14, 15, Table 01]." - I would reword this sentence as it is not entirely clear.

8. I would suggest putting the criteria of Yamaguchi into a table to make it easier to read.

9. I would also wonder if it would be worth reflecting on whether the patient should have been considered for a trial of TB therapy alongside his
immune-suppression with corticosteroids, particularly in view of his rapidly deteriorating status, the high incidence of TB within Sri Lanka and the possibility for corticosteroids to exacerbate TB infection.

- Statement added.

10. At the time of steroid administration i don’t feel that TB had not been absolutely excluded on the cultures and although his mantoux was negative we can find false negatives in patients with immune compromise. This therefore raises a question about whether he was immune-competent as the authors suggest. Presumably he had a degree of immune dysfunction due to Administration of TB therapy would have required the administration of a higher dose of steroid due to the interaction with rifampicin, but I think would have been worth considering. If it was considered then it would be worth providing an explanation as to why it was not administered. There may be valid reasons such as the concern of further liver toxicity.

Though complete exclusion of immunodeficiency was not feasible patient is less likely to be an individual with a pre-existing immune-deficiency due to following reasons

- apparently healthy life he enjoyed until the onset of the current illness.
- history of recurrent infections to suggest immunodeficiency is absent.
- most important cause for acquired immunosuppression like HIV was excluded by repeated screening for HIV-ELIZA.
- Normal count and morphology of leucocytes (including lymphocytes), adequate levels of serum globulins
On the other hand long duration of the deteriorating illness without a proper
treatment itself would have lead to a compromised immune system which might
show negative mantoux cannot be disregarded.