Reviewer's report

Title: A 65-year-old woman presenting with lung mass and pericardial effusion: a case report

Version: 1 Date: 2 February 2012

Reviewer: ARGYRIS TZOUVELEKIS

Which of the following following best describes what type of case report this is?: Unexpected or unusual presentations of a disease

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?: No

Is this case worth reporting?: Yes

Is the case report persuasive?: Yes

Does the case report have explanatory value?: Yes

Does the case report have diagnostic value?: Yes

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

Is the anonymity of the patient protected?: Yes

Comments to authors:

This is an interesting case of a patient presenting with clinical and radiological findings highly compatible with bronchogenic carcinoma that lastly a thorough examination complemented with lung biopsy revealed non-caseating granulomas indicative of sarcoidosis.

Major comments:

This is one of the few sarcoidosis cases in the literature, to the best of my knowledge, presented as lung cancer. I strongly agree with the view of the authors that when encountering with an atypical presentation lung and lymph node (when enlarged) biopsies should be obtained to exclude malignancy (lung cancer, lymphomas etc). In addition authors should also state that not only sarcoidosis can mimic lung cancer but can also predispose to lung cancer.
although a large study by Romer et al. ERJ 1998 in 555 Danish patients failed to confirm such a relationship. Nevertheless there are several studies in the literature supporting this relationship since microsatellite instability was also reported in sarcoidosis patients (Vassilakis et al. AJRCCM 1999). Therefore authors should state at the time point they performed the thoracentesis that this intervention was done to exclude malignancy since sarcoidosis may also predispose to lung cancer especially in a patient with high index of suspicion for lung cancer.

They should also mention that pleural effusion in sarcoidosis patients is an extremely rare manifestation of disease (incidence of 0.7% to 10%) and is more common in patients with active parenchymal disease). Suggested mechanisms are presumably similar to that of other infiltrative diseases. Involvement of the pleura may lead to increased capillary permeability with minimal pleural space inflammation. And they should bear in mind that not every PE in patients with sarcoidosis is related to disease itself. Therefore, sarcoidosis patients that present with PE should be carefully evaluated for other coexisting conditions including tuberculosis, congestive heart failure and malignancy. Small PE attributed to disease itself do not need corticosteroid dose escalation since they usually exhibit self resolution. (Anevlavis et al. Respiration 2012)

Minor comments:

There are some typing - language errors i.e page 7, line 16...not reliable should be non reliable....that should be edited accordingly

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