Author's response to reviews

Title: A rare case of Hepatitis C virus associated polyarteritis nodosa: a case report

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Author's response to reviews: see over
The editorial committee,

Journal of Medical Case reports,

Dear sir/madam,

**MS: 7272470173197977**

*A rare case of Hepatitis C virus associated polyarteritis nodosa*

Thank for the comments on our case report. We have done the necessary amendments suggested by the reviewers.

The changes made are underlined in the revised manuscript and are uploaded with this cover letter via the submission process.

We have addressed the required formatting changes of the manuscript to conform to the journal's style.

1. We have changed the study design in the title as “Hepatitis C virus associated polyarteritis nodosa: a case report”
2. We have included the ethnicity of the patient in the case presentation section as “Sri Lankan Tamil”
3. We have removed the figures from the main manuscript and have uploaded separately

We have also addressed the 2 reviewer’s comments.

- **Reviewer 1: Marco Cei**

  1. We agree to his comment that “we should only speak of a possible association between HCV infection and PAN and a causative link is only speculative for a case report like this one”. So we have revised the conclusion as “In conclusion we would like to highlight the possibility of HCV infection being capable of inducing a fulminant vasculitis in the form of PAN”

  2. Regarding his second comment, our patient clearly suffered an acute coronary event in his second admission. He developed a classic ischemic chest pain with shortness of breath and autonomic symptoms and the ECGs taken showed dynamic antero-lateral T wave inversions (L1, aVL, V2-V6). His cardiac troponin I was negative. But the immediate 2D echo showed global hypokinesia with dilated cardiomyopathy.
He had been a heavy smoker but had not had any other coronary artery disease risk factors. **There is a possibility that the acute coronary event was related to the vasculitis process, especially considering his young age and in the absence CAD risk factors except for smoking.**

**Reviewer 2: Mårten Segelmark**

1. We have used the ACR (American College of Rheumatologists) criteria to diagnose PAN. We accept the comment that the CHCC (Chapel Hill Consensus Conference) nomenclature which is relatively recent and widely accepted should have been considered here. Our patient fulfills the CHCC criteria for classic PAN as well. Furthermore his skin biopsy revealed a **perivascular lymphocytic and neutrophilic infiltration with fibrinoid necrosis of the vessel wall with leucocytoclasia and red cell extravasations.** The features were suggestive of a small and medium vessel vasculitis compatible with polyarteritis nodosa. However his pANCA (perinuclear) became positive which can rarely occur in PAN (His cANCA – cytoplasmic was negative).

We have not performed immunofluorescence on his biopsy but as you have pointed out the reduced compliment levels (both C3 and C4) were in favour of immune complex mediated pathology. But he had no renal involvement and biopsy didn’t show small vessel vasculitis. This excludes the possibility of a small vessel vasculitis like microscopic polyangitis. But we agree with the fact that the diagnostic nomenclature should be changed and have replaced the term PAN with cPAN (classic Polyarteritis nodosa) and have considered the CHCC nomenclature in our report.

2. We agree that the follow up was not long enough. The case was compiled just 6 weeks after the diagnosis. But **we have been following him up in our clinic now for nearly 6 months without any relapse. HCV related vasculitis has a good prognosis with antiviral therapy. As you have suggested this event free follow up also strengthens our diagnosis.**

Yours sincerely,

Dr. Damith Rodrigo