Author's response to reviews

Title: Postpneumonectomy-like Syndrome: A Rare Case with Review of Literature

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Author's response to reviews: see over
Cover Letter

Dear Editor,

We thank you for each individual author’s comments to improve our manuscript. We have addressed each and every item in the following manner:

From Reviewer 1:

1- Patient's presentation needs more elaboration. You described that patient was having Shortness of breath for past 6 months. Based on your case description the patient was treated for TB 40 years. Did he have any symptoms during these past 40 years? Was he followed up by any other physician during all this time? Was there any previous imaging for review? Did he have repeated pulmonary infections in these past 40 years? This would help establish cause and effect.

We expanded the case presentation to include more details about the patient's pulmonary status during the 40 yrs from treatment of TB to the point of presentation. Following TB infection and treatment the patient relocated countries and was not followed by a physician until he started seeing our pulmonary group. The patient had multiple exacerbations of his bronchiectasis and COPD but none were severe enough to require hospitalization. We have added several images taken prior to the patient’s admission for review.

2- You mentioned that patient's clinical presentation was secondary to Cor pulmonale. Please mention the echocardiographic findings. It is not clear if his shortness of breath was secondary to cor pulmonale, autopneumonectomy of his right lung or postpneumonectomy like syndrome.

One year prior to presentation, an echocardiographic assessment demonstrated left ventricular hypertrophy with moderate pulmonary hypertension, and a dobutamine stress echocardiogram demonstrated a defect in the inferior wall consistent with a previous infarction.

3- Your case does not describe the findings classically seen in Post pneumonectomy/ Post pneumonectomy like syndrome. Did the patient have recurrent pulmonary infections? Did the patient have any stridor? Was there any evidence of tracheal/left main stem bronchus compression secondary to mediastinal shift? If yes, please provide CT images of those findings.

The patient did not exhibit stridor at any point. However, the patient did have recurrent and multiple exacerbations of his bronchiectasis and COPD. Also, as demonstrated on the CT scans, there is marked trachea/and left main bronchus compression secondary to mediastinal shift which are seen in patients with postpneumonectomy-like syndrome.

4- You mention in your report at multiple places that Autopnuemonectomy is caused by surgical resection. This certainly is not true considering the fact that surgical pneumonectomy is not a spontaneous process.
Noted and corrected, thank you.

5- You mention in your report that it's important to promptly recognise and treat endobronchial tuberculosis. The term endobronchial would not be appropriate here since, its primarily the parenchymal infection which would finally lead to destruction of lung tissue and later on would lead to fibrosis. Thus "endobronchial tuberculosis" can be changed to "pulmonary tuberculosis"

Noted, thank you for the suggestion.

6- It is unclear what was the etiology of the patient's acute respiratory distress during his hospital course. Please elaborate.

The patient’s presentation was attributed to a cardiac arrhythmia secondary to his extensive lung disease and was treated with calcium channel blockers to control his heart rate. However, four days into his hospital course, he became lethargic with a three gram drop of his hemoglobin and subsequently went into cardiac arrest. The patient was immediately intubated and was resuscitated according to ACLS protocol. During the arrest he was noticed to have profound coffee ground emesis. Despite resuscitation efforts, the patient remained pulseless and subsequently died.

From Reviewer 2:

Please include patient's chest x-ray before her illness started if there is any available.

We have included a chest x-ray from one year prior to the admission.

From Reviewer 3:

(1) I would like the case presentation to include more information. As an example, please include medications, pertinent negatives on history, specific vital signs, a more detailed report of the physical examination. In addition, it would be helpful to have pertinent labs and more diagnostic studies; chemistries, CBC, ABG, LFTs, BNP, EKG (Possibly right sided?), Echo, if available would provide a more complete picture of the patient's presentation. The chest imaging is interesting, but I would like to see mediastinal images of the CT as seeing the distortion of the mediastinal structures is important in a patient who was ultimately deemed to have cor pulmonale due to anatomical distortion and parenchymal lung disease.
We have expanded the case presentation and included more diagnostic values including chemistries, CBC, LFTs, BNP, and electrocardiogram. We have also included several mediastinal images of the CT more to display the anatomical distortion that occurred.

(2) The discussion section also needs to be expanded as well. I think the report would be strengthened by a discussion of how this case differs from previous reports (described in the Discussion) and what additional information or insight into the disease has been learned.

We have noted the above suggestions and have made changes accordingly.

To the editor, please also be aware that we have all discussed and re-evaluated the contributions of each individual author and have made adjustments to the order in which the authors are to be listed.

Thank you again for your time and consideration of our manuscript.

Yours very truly,
Dr. Jennifer Kam
Article Title: Postpneumonectomy-like Syndrome Presenting in a Patient with Treated Pulmonary Tuberculosis: A Case Report

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**Running Head:** Postpneumonectomy-like Syndrome

**Consent:**
Written informed consent was obtained from the patient for publication of this case report and accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal.

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