Reviewer's report

Title: Diffuse leptomeningeal gliomatosis initially presenting with intracranial hemorrhage: a case report and literature review

Version: 2 Date: 9 February 2015

Reviewer: Joseph Burns

Reviewer's report:

Zhu and colleagues submit for review a case report of leptomeningeal gliomatosis (LMG) presenting as intracerebral hemorrhage (ICH). It is an interesting, unusual presentation of an unusual condition that should be of interest to readers of the journal. Overall, it is a worthy case report. However, some specific issues should be addressed:

1. Minor essential revision. The authors claim that this would be the first published case of LMG presenting as ICH. By their search methods this is true. However, it would actually be the second case, the first being: Clinical Reasoning: a 52-year-old man with spells of altered consciousness and severe headaches. Burrus TM, Burns JD, Huston J 3rd, Lanzino G, Rabinstein AA, Uhm JH. Neurology. 2009 May 26;72(21):e105-10. doi: 10.1212/WNL.0b013e3181a711b4.

2. Major compulsory revision. The paper is fairly well-written, but certainly needs extensive English language editing by a native speaker before being ready for publication.

3. Minor essential revision. What was the patient's blood pressure on admission? Did he have a history of hypertension? The hemorrhage seen in this patient is really intraventricular, and primary IVH without a history of trauma, hypertension, and no aneurysm or AVM would have been early indicators that something unusual was occurring.

4. Major compulsory revision. Line 74: what specifically was the initial treatment for decreasing ICP and vasospasm? Were corticosteroids used? If so, how much and for how long? Application and withdrawal of steroids could explain the waxing/waning course.

5. Minor essential revision. Line 79: the lesion referred to in the right temporal horn is actually at the right temporal tip.

6. Minor essential revision. What occurred between acquisition of the scans showing nodular enhancing lesions and deterioration on day 15? What was the working differential diagnosis at that time? What diagnostic tests were done and what therapy was administered?

7. Major compulsory revision. Line 98: what was the serum glucose at the time of the first lumbar puncture?

8. Discretionary revision. Line 102: was flow cytometry on the CSF performed?
9. Minor essential revision. Line 104: which tumor biomarkers were sent? Also, were these from serum or CSF?

10. Major compulsory revision. What occurred between days 15-34? What was the patient’s condition? Did he really suddenly deteriorate, or did he slowly deteriorate with sudden acceleration of his worsening on day 34? What Was the differential diagnosis during this time? What diagnostic tests were done and what therapy was administered? Again, details of the use of corticosteroids is important in understanding the case?

11. Minor essential revision. Why did the team taking care of the patient wait until day 46 to biopsy the patient? Clearly the CT with contrast and MRI, performed much earlier in the course, indicated that something much more than primary intraventricular hemorrhage was occurring.

12. Minor essential revision. Lines 116-120: this information should be supplied earlier in a brief single paragraph methods section.


Level of interest: An article of importance in its field

Quality of written English: Not suitable for publication unless extensively edited

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:

My only competing interest is being co-primary author of a case report describing the same disease process (see my review).