Author’s response to reviews

Title: Atypical frontal lobe seizure as the first manifestation of gall-bladder cancer: a case report.

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Response to reviewer's comments:

Monica Maria Francesca Puligheddu (Reviewer 1): In this manuscript the Au's, describe an atypical case of focal seizure as primary manifestation of Gall bladder cancer (GBC).

Introduction: there is a meagre examination of literature about GBC and its typical manifestations. According with word counting limit, it would be useful to better scrutinize the literature.

As per the suggestion by the reviewer we reviewed the literature and found that there is scarcity of data regarding neurological presentations in Gall Bladder Cancer. However, we tried to put it into the revised manuscript. Background and discussion.(page number-3 and 5, line number-77-81 and 127-129).

Case presentation: quite well described in clinical term, good analysis of the video although the lack of EEG ictal and/or interictal, is the major problem in this case description.

We would like to thank the reviewer for the comments. Intreicrtal EEG was done in this patient and it did show generalized slowing of background but we could not find a focus of origin. Ictal EEG could not be done and it is a limitation to the study and authors have mentioned it in the revised manuscript.(page number-6, line number-154-157)

Brain MRI description: the interpretation of the described lesion is, to me, a bit incomplete and confused. It is not clear to me the term of focal atrophy. What exactly intend the Au's? If, as probably is, the primary explanation is an ischemic lesion, then the correct term would be, for
example "post infarction malacia with residual gliosis" or similar. This, to better define the lack of tissue related to the vascular lesion.

In Fig 1 A and B is represented the T1 hypointense and T2 hyperintense lesion in left frontal area; a coronal projection could be useful to better define the morphology and dimension of the lesion. Since the nature of this lesion is not completely clear, as the Au's affirm, an evolutive (1 or three month) control (if available) it would be useful.

Another useful possibility to discriminate between vascular or repetitive lesion, could be a H1 MRI spectroscopy if available.

Authors completely agree with the reviewer's comment and we have changed the term focal atrophy now with post infarction encephalomalacia left frontal area near frontal eye field in the revised manuscript. (page number-2,4,5,6, line number-60-62,106-107,146-147, 159-161). The affected area could possibly explain the seizure semiology in our patient. Follow up MRI brain is not available with us and as the area affected was very small and appeared to be malacic H1 MRS was not possible.

Videos: a description of the state of awareness of the subject would be helpful. Again, the lack of EEG is the most critical observation of this case presentation.

As suggested by reviewer, videos of ictal and post ictal recordings showing state of awareness of the patient is being submitted in the revised manuscript. (additional file video-1.mov and additional file video-2.mov) (video legend: page number-10, line number-248-253). Inter-ictal EEG of the patient showed generalized slowing of background as described in the revised manuscript. (page number-6, line number-154-155).

In conclusion this case is quite well described, interesting the fact that focal seizure is the primary manifestation of GBC but specifically for that, the presence of ictal and or interictal EEG recordings added with ocular EOG derivation would improve the description.

We agree with reviewer's comment but we could not do ictal EEG along with EOG which is a limitation to this case report as mentioned in the revised manuscript. (page number-6, line number-155-157)