Author’s response to reviews

Title: Limited efficacy of adalimumab in the acute phase of serpiginous choroiditis refractory to corticosteroid and cyclosporine, A case report

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RESPONSE TO REVIEWER

We wish to express our strong appreciation to the Reviewers for their insightful comments on our paper.

Reviewer reports:
Pradeep Venkatesh, MD, D N B (Reviewer 1): Please include the following reference and mention the use of pulse cyclophosphamide in the management of acute macular serpiginous choroidopathy.
Indian J Ophthalmol. 2015 Apr; 63(4): 318-322

Response: We thank the Reviewer for this pertinent comment. In accordance with the Reviewer 1's comment, we have changed the expression of recent reports about the treatment . (p. 4, line 17– p. 9, line 18) from:

“Recently, some reports showed efficacy of biological drugs such as infliximab3 and adalimumab4,5.”

to

“Recently, some reports showed efficacy of biological drugs such as infliximab3 and adalimumab4,5 and intravenous pulse cyclophosphamide.6”

We have also added the following reference, and changed the reference number.

Ryoji Yanai, M.D., Ph.D. (Reviewer 2): This manuscript is the first report on the unssuccess of vision recovery by the anti-TNF-alpha antibody treatment addition to corticosteroids and immunosuppressants on the acute phase of serpiginous choroiditis.

The manuscript was well studied and writing in English. However, the reviewer has some concern about the less conclusion, and the authors also describe this point in the Discussion section.

Since the phase of treatment with anti-TNF-alpha antibody was different from previous reports (Refs. 4 and 5), we could not compare with the efficacy of the drug be overestimated or not.

It was less evidence to conclude the limitation of the efficacy of adalimumab because of the running more than one treatment in the medication, and the outcome might be continued in this case.

Response: We thank the Reviewer for this pertinent comment.
As the Reviewer 2 indicated, we cannot draw any conclusion from a single case, and the limitation is discussed in p. 5, line 44. We added another sentence to avoid misunderstanding.
“In fact, progression was controlled with adalimumab after eight months in the present case. “

Nikolaos Theodor Voutsas, M.D. (Reviewer 3): Accept without revision.
Response: Thank you for the very positive evaluation.

Ariel Schlaen, MD (Reviewer 4): This is a well written and interesting case report. However, there some aspects of this manuscript must be revised:

Minor revisions:

1) Abstract:
Case Presentation:
"...An 18-year-old woman presented with severe vision loss in the both eyes…".
It is better to write "in both eyes"
Response: The sentence was revised accordingly.

2) Page 5, line 4: "transvenous" must be replaced by "intravenous"
Response: The term was revised.

3) Page 5, line 30: "progresed" must be replaced by "progressed"
Response: The typo was corrected.

Major revision:
1) The lesions observed are multifocal, located in posterior pole and also midperiphery. This type of lesions is suggestive of serpiginous like choroiditis (1). Notwithstanding, immunological test was negative for tuberculosis, which led to the indication of immunosuppression. However, failure of immunosuppression to control progression of the disease is a situation that may lead to consider to treat with anti TB medications, and also to consider other etiologies such as syphilis and herpes. These insights should be developed thoroughly in the discussion section, in order to explain why it was maintained only immunosuppression when the disease progressed.


Response: Thank you for the important comment. We agree that it is not always easy to differentiate serpiginous choroiditis and tuberculous serpiginous-like choroiditis. In addition to the negative result of quantiferon, OCT findings reported in serpiginous-like choroiditis including vitreal hyper-reflective spots, intraretinal edema, sub-retinal pigment epithelium (RPE) drusenoid deposits, choroidal granulomas were absent in our case. (p. 4, line 41) Although not specified in the text, we also tested treponema pallidum particle agglutination, immunoglobulin to HSV showing negative result. Thus, tuberculous serpiginous-like choroiditis was not strongly indicated. Considering side effects of anti-TB medications, we prioritized immunosuppressive treatment. A paragraph was added in the discussion.

“Differentiation of serpiginous choroiditis and tuberculous serpiginous-like choroiditis is not always easy. In the present case, unsuccessful response to immune suppressive treatment made us re-consider tuberculous serpiginous-like choroiditis and other infectious etiology. In fact, multifocal appearance was suggestive of tuberculous serpiginous-like choroiditis.8 However, repeated QuantiFeron test was negative and OCT features reported in tuberculous serpiginous-like choroiditis was absent in the present case. Blood test did not indicate other possible etiologies such as syphilis or herpes. Considering side effects of anti-tuberculosis or anti-viral treatment, we continued immune suppression and finally succeeded to cease progression. Careful evaluation is necessary for such refractory cases.”