Author’s response to reviews

Title: Pseudotumour cerebri associated with Mycoplasma Pneumoniae infection and treatment with levofloxacin: a case report

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Response to Reviewer 1.

We agree that the association of Pseudotumor cerebri with infections on one hand and antibiotics in the other hand is not novel in itself, as Reviewer 1 said. However the originality we want to point out with our case report is the synergic interplay between different factors, in particular infection and therapy. Indeed the history of our case well shows an interesting temporal sequence of two steps: we suppose that the initial symptoms of Pseudotumor cerebri (headache onset) were given by mycoplasma and the subsequent severe worsening of headache and sixth cranial nerve were due to the detrimental adjunctive effects of levofloxacin on a CSF circulation already compromised by mycoplasma infection. We think that this peculiarity of our case report may be useful to make physicians aware of the potential synergic role of infection and drugs together, thus helping in a better decision making. We specified these concepts in Discussion, page 5 and 6". 
Response to Reviewer 2.

1. We corrected “caucasian” with “White Italian” as you kindly suggested (Case report, page 2, line 37). In our opinion the ethnicity could be relevant as we can’t exclude that genetic factors linked to ethnicity can influence predisposition to pseudotumor cerebri.

2. We wrote the actual dose of prednisone as you suggested: oral prednisone 50 mg/day (0.75 mg/kg/day) (Case report, page 4, line 115)

3. Correct spelling mistakes, e.g. in the supplementary data time line table. We corrected as follows:

   “ophtalmological” --> “ophthalmological”

   "artralgia" --> "arthralgia"

4. The correct dose of levofloxacin was 500 mg once a day (Case report, page 3, line 89)

5. We corrected it as suggested: "Lancaster test" --> "Lancaster red-green test" (Case report, page 4, line 99)

6. We change 24-hour ECG Holter with 24-hour Ambulatory Blood Pressure Monitoring because of a writing mistake (Case report, page 4, line 105)

In the discussion:

1. The delay of lumbar puncture was due to the fact that during the first days of hospitalization the symptoms (headache and diplopia) were dramatically and spontaneously reduced (page 5, lines 144-145).
2. A short therapy with oral prednisone was attempted with the aim of promoting the reduction of the symptoms which had already spontaneously started (page 5, lines 145-147).

3. We decided to omit that, as suggested by the Reviewer 2; LP was performed in Intensive Care Unit for extreme safety and not for a real risk. Furthermore, the decision was due to logistical reasons (availability of more adequate spaces and instruments)

4. CSF oligoclonal bands were absent on CSF and blood tests. It support the absence of neurological inflammatory diseases. (page 5, lines 150-15)

5. A 24-hour Ambulatory Blood Pressure Monitoring was performed because a positive family history for essential hypertension at a young age was reported (page 5, lines 148-149)

6. In our patient OP was 20 cm H2O, but the presence of 1) clinical signs and symptoms of raised intracranial pressure (headache, blurred vision, papilloedema, abducent nerve palsy) without additional abnormal neurological signs; 2) normal magnetic resonance imaging and 3) unremarkable examination of CSF constituents are supportive for a diagnosis of “probable” PTCS, according to the definition of probable PTCS given by Tibussek et al. (page 5, lines 158-163).

Response to Reviewer 3.

We agree that the case report will give a valuable contribution in helping practical decision making.

As regards language corrections we have already submitted the manuscript to a mother-tongue English translator.