Author’s response to reviews

Title: Clinical course of IgG4-related hypophysitis presenting with focal seizure and relapsing lymphocytic hypophysitis.

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Author’s response to reviews:

September 26, 2015
Re: MS: BEND-D-15-00045

Dear Editor-in-Chief

Thank you very much for reviewing our manuscript entitled “Clinical course of IgG4-related hypophysitis presenting with focal seizure and relapsing lymphocytic hypophysitis” by Ngaosuwan et al. We are pleased to hear that we were given an opportunity to revise our manuscript and resubmit it for consideration for publication in BMC Endocrine Disorders.

Below, please find a detailed point-by-point response to the reviewer comments. We have structured our manuscript in order to convey our findings more clearly and precisely according to your suggestion. We hope that our revised manuscript would suit the reader’s interest and be acceptable for publication in BMC Endocrine Disorders.

We really appreciate the reviewer comment as well as your comment in order to improve our manuscript. We thank you both very much for your time and effort in reviewing our manuscript.

Sincerely,

Kanchana Ngaosuwan, MD
Corresponding author

Response to the reviewer’s comments
Re: MS: BEND-D-15-00045

Reviewer #1

Case presentation:

1. Page 3, lines 19-24: I would rephrase this part, making clearer the history before and after admission.
As suggested by the Reviewer, we have rephrased the sentences in line 1-5 at “Patient information and Clinical findings”. These sentences described the patient’s chief complaint then explained his 2-year past illness as follows:

“In September 2013, a 43-year-old Thai man was admitted to the hospital with three consecutive episodes of rhythmic jerky movement of left face and arm, as well as speech arrest. These symptoms spontaneously resolved prior to hospital arrival. He also had a two-year history of malaise, loss of appetite, cold intolerance, 10-kg weight loss, headache, and loss of libido.”

2. Page 3, lines 41-42: the authors should clarify why they delayed the pituitary biopsy, and how was the patient after 6 weeks (or more?) of treatment with corticosteroids. As suggested by the Reviewer, we have added the reason of delayed the pituitary biopsy in lines 41 as follows:

“...Since the diagnosis was subacute cerebral infarction, the pituitary biopsy was postponed until six weeks follow-up. We sent separated pituitary tissue for pathologic examination, one for local pathologist and other to external pathology laboratory. …”

The patient’s symptoms and signs after 6 weeks and more of the treatment with corticosteroid were described already in lines 51-52 and lines 56-57 as follows:

“...Clinically, his headache resolved, his seizure remained in remission and he appropriately regained weight…”

“...The patient also remained seizure free after the initial steroid administration. In May 2014, prednisolone was further reduced to 7.5 mg per day…”

3. Page 4, line 6: what do the authors mean for 'lesional involvement'?

Lesional involvement means the inflammation progressed from the pituitary to the meninges around the optic chiasm. However, we have explained it already in the “Discussion” in page 5, lines 59-60. Therefore the phrase “lesional involvement in page 4, line 6 would be deleted as follows:

“...The study also showed more hyperintense T2W change and mild heterogeneous enhancement at the optic chiasm, suggesting an increase in swelling of the optic chiasm (fig. 2C-D)…”

4. Page 4, line 25: what do the authors mean for '..of prednisolone increment'? The sentence should be rephrased.

As suggested by the Reviewer, we have rephrased the sentences in line 24-25 as follows:

“...Pituitary MRI at 4 months after established diagnosis showed markedly decrease in size of sellar mass and decrease in swelling of the optic chiasm (fig. 2E-F) without abnormal brain parenchymal lesion....”

Discussion:

1. Page 5, line 43: at this point is not clear which 6 cases the authors are talking about.

The six cases (five cases were from the previous reports and the last was the presented case.) were reviewed due to the clinical hypophysitis were recurred or worsening during the steroid
therapy and five of six cases had the initial diagnosis of lymphocytic hypophysitis. We have modified these sentences in page 5, lines 35-45 and illustrated with table 2.

“..Up to six cases revealed enlarging masses on imaging or developed new symptom relating to the sellar mass during steroid therapy [2, 6, 11, 18, 27]. These symptoms included visual disturbance, headache, diabetes insipidus or progression of hypopituitarism. Steroid dosage at the point of relapse varied from 30 mg of prednisolone per day to hydrocortisone replacement therapy. All patients eventually required up-titration of steroid or additional immunosuppressant therapy to control their relapsing clinical symptoms. Five out of six cases were also initially diagnosed with lymphocytic hypophysitis where three of these cases also had pituitary biopsy and histopathology study prior to their diagnosis (table 2)…”