Author’s response to reviews

Title: Hawely retainer and lichenoid reaction - an uncommon oral contact reaction case report.

Authors:

mahmoud elhadad (elhadad2008@gmail.com)
yasmeen gaweesh (yasminegaweesh@gmail.com)

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Author’s response to reviews:

Van der Waal (Reviewer 1): There is not much difference between fig.1 and the figure after six months (fig.8). If there is any improvement, it may be the result of the corticosteroid application. Because of the poor quality of fig. 5 it is impossible to see if there is epithelial dysplasia. When there is, indeed, dysplasia, my working diagnosis would be erythroplakia, carrying a high risk of malignant transformation.

Figs. 2,3,4,6 and 7 are not relevant.

Dear Prof Dr Van der Waal,

• Figure 8 shows partial resolution of the lesion. Resolution of the lesion was described as partial resolution instead of complete resolution according to your commentary and comments of other reviewers as shown in the management section line 1 page 4, also corticosteroids were only used for a period of two weeks to relieve symptoms and this was pointed to as a limitation of the study because it confused the source of improvement of the lesion as mentioned in the discussion section line 15 page 5.

• Furthermore, OLR typically resolves within weeks to months after removal of the causative material, but delayed responses may also occur according to the following references:


• In the presented case, the histopathological features matched those of lichen planus and lichenoid lesions and were far from those suggestive of erythroplakia. That is why a final diagnosis of lichenoid lesions with dysplastic changes was reached as mentioned in the discussion section.

• All histopathological pictures were replaced by new pictures captured by a computerized microscope under low and high magnification. Epithelial dysplasia was more clear in the new pictures.

Saman Warnakulasuriya (Reviewer 2):

1. In the abstract, case-presentation section, should include. The retainer was withdrawn from use.

2. In figure 5 legend more histopath description should be stated. What about the chronic inflammatory cells which is important for the diagnosis. Kindly draw an arrow to indicate where dysplastic features are in the epithelium. Please include more figures of histopathology at different levels of the specimen.

3. In Fig 8 there is still residual erythema. So, it's wrong to say complete resolution. Please discuss this in the discussion. Change: complete to partial resolution

4. Patch testing in many centres is done with commercially available patch test kit. Was this not available to you? Kindly discuss as a limitation in the discussion. Please cite J Oral Pathol Med. 2016 Jan;45(1):48-57 on the role of patch testing...

5. Fig 6 is not needed

6. The discussion says "atypical dyplasia" confirms OLL. This is a wrong expression. Dysplasia is not common in OLL.

7. In the discussion "a triad" is mentioned. Not clear what this triad is?

8. Under histopathology it is important to describe what dysplastic features were found.

Dear professor Warnakulasuriya,

1. The abstract was modified and included “the retainer was withdrawn from use” abstract section line 10, page 2.

2. Histological analysis section was modified and all pictures were replaced by new ones captured by a computerized microscope. More sections under different levels were included. Histopathological analysis section page 3.
3. Complete resolution of the lesion was changed to partial resolution according to your kind commentary. Management section line 1 page 4.

4. Commercial patch test kit wasn’t available, and this was discussed in the discussion section as a limitation line 13 page 5.

5. Figure 6 was removed

6. Dysplasia was mentioned to be a possible feature for OLL not a common one. Discussion section paragraph 3, 4 and 5, page 4.

7. The word triad was removed to prevent confusion. Discussion section paragraph 1 page 4.

8. Histological analysis section was modified, more figures were added showing dysplastic features such as hyperchromatism, pleomorphism, prominent nucleoli and mitotic figures. Histopathological section line 25, page 3.

Dante Antonio Migliari (Reviewer 3):

1. The title should be reviewed: It is nor a rare case report, but an uncommon reaction.

2. You should Discuss your case and not adding lots of information from the literature. It does not add up. And it is quite boring.

3. You have a made a hypothesis of erythroplasia. There were two lesions. Why did you make that diagnosis?

4. English is not OK.

5. The lesion did not disappear completely, but you have stated differently.

6. This is a contact reaction, supposedly. Why have you mentioned GVHD? There is no relation. It is confusing.

7. Patch test is O.K. But acrylic can cause a chemical reaction and not necessarily a Type IV reaction

Dear Professor Migliari,

1- The title was reviewed and modified to “an uncommon oral contact reaction”. Title section line 2 page 1.

2- The discussion section was modified, and unnecessary literature was removed.

3- The hypothesis of erythroplakia was made as a differential diagnosis based on the first appearance of the lesion because of the fiery red color and the burning sensation described by the patient and it was excluded later by histopathological analysis. Discussion section line 11 page 4.
4- English was revised and corrected.

5- Complete resolution was changed to partial resolution. Management section line 1 page 4.

6- GVHD as a type of lichenoid reactions according to van der Meij 2003 and it was removed to prevent confusion.

7- Chemical burns are usually more severe and may cause sloughing in all contact areas, but a contact reaction mainly causes erythema, sloughing or pigmentation which occurred in our case.

Lastly, we would like to thank all the reviewers for their kind comments, these comments were very helpful to make this case report clearer and more precise. we are open for any further discussion.

Thank you,

Mahmoud Elhadad