Author’s response to reviews

Title: Recurrent retroperitoneal abscess after biliary tract surgery in an elderly patient: a minivasive non-surgical approach and its consequences. A case report

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Author’s response to reviews:

To: Prof. Michael Kidd

Editor-in-Chief

Journal of Medical Case Reports

Subject: Resubmission of the manuscript n. JMCR-D-18-00482 entitled "Recurrent retroperitoneal abscess after biliary tract surgery in an elderly patient: a minivasive non-surgical approach and its consequences. A case report"

Dear Prof. Kidd,
Thank you for giving us the opportunity to resubmit our manuscript after the peer review process. The comments of the reviewer were very appropriate and prompted us to ask you a time extension to modify the manuscript accordingly.

We modified the text of the manuscript in accordance with the reviewer’s requests. All modified parts are underlined in yellow. We made also some minor changes to correct misspellings and small terminological incoherencies that were present in the original. Below this message you will find a point-by-point response to the reviewers’ comments.

In our opinion, the manuscript has benefited very much from the peer review of your Journal and we want to thank you once again for that. We hope the manuscript is now acceptable for publication.

Best regards,

Vincenzo Davide Palumbo

Author point-by-point reply to Reviewer’s Comments

Reviewer 2 (R2) Comment #1 (C#1): The culture report is not included anywhere in the report. What are the differential diagnosis for pathogen, what antibiotics were administered to the patient?

Author Reply: We thank the reviewer for this comment. The only one drainage fluid sample collection for culture was performed during episode n. 3 (june 2016). It included cultures for bacteria (aerobic and anaerobic, including Mycobacterium tuberculosis) and fungi. Unfortunately it resulted completely negative. Antibiotic therapy provided broad-spectrum drugs, such as intravenous Piperacillin-Tazobactam 4.5 mg twice daily or Ceftriaxone 2 g once daily and intravenous Levofloxacin 500 mg once daily.

R2 C#2: Please mention some details about co-morbidities of given patient.

AR: Co-morbidities are already mentioned into the text. The patient suffered from high blood pressure and type II diabetes.
R2 C#3: What are the possible reasons for recurrent infections?

AR: Patients with chronic granulomatous disease (CGD), a rare genetic disorder characterized by recurrent infections, are at risk for liver abscess. In our case, we think that the multilocularity of abscesses was the real cause of recurrence. Likely, the drainages were only partially effective in purulent fluid removal. Therefore, a residual small amount of microorganisms could be the effective cause of the recurrences, probably in conjunction with immunodepression periods.

R2 C#4: Please remove less relevant discussion of causes of liver abscess/ classification and possible surgery vs percutaneous drainage.

AR: We actually do not agree with this comment of the reviewer, since in our opinion pathogenesis of liver abscesses and their nosological classification is very important to better understand the case (and reviewer’s questions are the proof of this). Furthermore, in particular for the presented case (elderly patient), we feel necessary to underline the importance of radio-guided drainage to avoid surgery. Nevertheless, if the Editor would ask us to modify the paper in accordance to this comment, we can do it in a further revision of the work.

R2 C#5: Was there any work up done for Tuberculosis?

AR: See Author Reply for comment #1

R2 C#6: Was there any radiological studies done to check for continual bile leakage/distal obstruction if prior surgery was an etiology for abscess?

AR: All clinical, laboratory and radiological findings were normal after cholecystectomy.

R2 C#7: Was there any evidence of infection when patient presented with lumber hernia? Was hernia symptomatic? Do you think nerve damage leading to loss of muscle tone in that area might be a possibility?

AR: When patient presented with lumbar hernia, there were no clinical or radiological signs of infection. No symptoms were reported, apart from the uncomfortable presence of the swelling in her right lumbar region. Likely, in accordance with reviewer’s comment, a nerve damage could be the cause of muscle weakness and subsequent lumbar hernia.