Author’s response to reviews

Title: Takayasu arteritis with pyoderma gangrenosum: case reports and literature review

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Author’s response to reviews:

Dear Dr. Fitzpatrick,

Thank you for the review of our manuscript “Takayasu arteritis with pyoderma gangrenosum: case reports and literature review” for consideration as a Case Report in BMC Rheumatology.

We appreciate the thoughtful comments from the editors and reviewers. We have prepared a point-by-point response below and made corresponding changes, which are highlighted in the manuscript. We believe that the manuscript has been strengthened with these revisions, and we hope that you find the revised manuscript acceptable for publication.

Thank you very much for your time and consideration.

Sincerely,

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Responses to Reviewer #1:

Comment 1: This manuscript illustrates two patients with pyoderma gangrenosum who developed TAK afterwards and reviews the literature about this issue. It is an important manuscript to remind physicians about this rare cutaneous complication of TAK.

Response: We thank the reviewer for these positive comments.

Comment 2: In the conclusions of the abstract, it is not possible to recommend considering TAK in young females with pyoderma gangrenosum. This association is very rare and the vast majority of patients with pyoderma gangrenosum do not develop TAK. Please change both conclusions in the abstract and at the end of the manuscript.

Response: We thank the reviewer for this suggestion. We have revised the conclusions in the abstract section (page 3, line 53) and the manuscript (page 11, line 244) as follows:

“It is important to remember the rare possibility of Takayasu arteritis in patients with skin lesions indicative of pyoderma gangrenosum of unknown aetiology. Obtaining the relevant history and regular monitoring of the arteries are necessary.”

“In conclusion, in addition to evidence from the available literature, our case reports illustrate the need to consider the rare possibility of underlying TA in all patients with PG, especially in young female patients.”

Comment 3: Background (page 4, line 86) please change "clinical manifestations of PG" to "pathology features of PG"

Response: We thank the reviewer for this suggestion. We have changed it (Background section, page 4, line 86).

Comment 4: Case 2 (Page 8 line 165) - The sentence "According to the ACR criteria, the vasculitis in this woman was classified as type V TA" is wrong. ACR classification criteria for TA does not approach the angiographic classification. Thus, even if the patient was classified as TA according to the ACR classification criteria, she presented type V according to Numano and Hata angiographic classification of TA.

Response: We thank the reviewer for pointing this out. We have changed this sentence (case 2, page 8, line 177) to “According to ACR criteria, this woman was diagnosed as TA.”
Responses to Reviewer #2:

Comment 1: Out of 18 cases with TAK and P, only two cases were in detail. Describe the details of the other 16 children in tabular form. Alignment needs to be done.

Response: We have described the details of 18 cases in Table 1 of the manuscript. Please see the content in the text.

Comment 2: English should be corrected in various places.

Response: We thank the reviewer for this suggestion. The English language of our manuscript has been edited by American Journal Experts.

Comment 3: Authors case description is not complete. Write in more details about your cases.

Response: We have added more details of our two cases to the text:

“Her complete blood count was significant for mild leucocytosis of 13.0×10⁹/L (3.5-9.5×10⁹/L), with 82% neutrophils, haemoglobin of 9.5 g/dL (11.5-15.5 g/dL), and a platelet count of 310×10⁹/L (100-350×10⁹/L). C-reactive protein was 20.2 mg/L (0-8 mg/L), and the erythrocyte sedimentation rate (ESR) was 105 mm/1st hour (<20 mm/1st hour). Renal and liver function, urinalysis, and coagulation profiles were in the normal range.” (case 1, page 5, line 101)

“In June 1998, she presented with rash with ulcerated pustules on the surface in the left lower extremity. The rash was gradually relieved after receiving asaisone (8 mg/d). Glucocorticoid was stopped in February 2000.” (case 1, page 5, line 112)

“Prednisone and cyclosporin A relieved the skin lesion, and the medicine was then tapered. Three years later, she developed multiple pustules in her left upper extremity. Investigations revealed a white cell count of 20.53×10⁹/L (3.5-9.5×10⁹/L), with 88.5% neutrophils and an ESR of 120 mm/1st hour (<20 mm/1st hour).” (case 2, page 7, line 142)

“Laboratory investigations showed that her ESR had increased to 43 mm/1st hour (<20mm/1st hour), and the CRP level increased to 20.55 mg/L (0-8mg/L). White and red blood cell counts, renal and liver function tests, serum complements, rheumatoid factor, antiphospholipid antibodies, antinuclear antibody, and antineutrophilic cytoplasmic antibodies were within normal range or negative.” (case 2, page 8, line 164)

“In view of scant evidence of active inflammation and development of the disease to the stenotic stage...” (case 2, page 8, line 178)