



SDI Review Form 1.6

Journal Name:	International Blood Research & Reviews
Manuscript Number:	2014_IBRR_15692
Title of the Manuscript:	Epidemiological and biological parameters of monoclonal plasma cell dyscrasias in thirty one patients consulting a Moroccan Pasteur Institute
Type of the Article	Original article

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This journal's peer review policy states that **NO** manuscript should be rejected only on the basis of '**lack of Novelty**', provided the manuscript is scientifically robust and technically sound.

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PART 1: Review Comments

	Reviewer's comment	Author's comment (if agreed with reviewer, correct the manuscript and highlight that part in the manuscript. It is mandatory that authors should write his/her feedback here)
Compulsory REVISION comments	Authors studied laboratory results of patients who had monoclonal immunoglobulin spikes This study being laboratory-based has a lot of flaws; (a) the results of the patients were not corroborated with their clinical condition or state. (b) The authors could not state whether the results were obtained at presentation or at what point in the treatment course this was done. (c) The diagnosis of plasma cell dyscrasias are mainly made by finding plasmacytosis in the patients bone marrow. This is different from monoclonal gammopathies (d) The aim of the study has been lost mid-way and needs to be was not achieved. Are the authors describing features of plasma cell dyscrasias? Or patients behaviour as regards carrying out their immunological tests? (e) Authors did not tell the readers why the patients did not carry out the tests, did the patients die? Were they referred?	I would first at all to thank you for your pertinent observations: a. The work was only based on detecting monoclonal immunoglobulin spikes and determining their type without doing a diagnosis. This was a big limitation of our work as it was indicated in the manuscript. Reasons behind this were: patients provided to us only their names and ages and not the name of their clinicians to contact them, sometimes doctor send sera of their patients without giving information about biopsy or patient state. We seek a lot about these information but they were not available in case notes. This is why we don't really know how many patients had CRAB features (f). The provided information was given in table 1. According to this table patients with hypercalcemia had no anemia or just evaluated haemoglobin level was not performed for those patients. Furthermore, information about creatinine to detect renal dysfunction in patients was not given. b. the results were obtained at presentation because any double immuno-electrophoresis or non-coupled to electrophoresis was excluded (during follow-up). c. there are many manuscripts in which Bone marrow aspiration measures are required for MG [Molle 2009. Current Trends in the Diagnosis, Therapy and Monitoring of the Monoclonal Gammopathies. Clin Biochem Rev. 30 : 93-103]. Moreover, Monoclonal gammopathies result from an overproduction of a single abnormal



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	Was it due to lack of finances etc? (f) How many of the patients had any of the CRAB features or other co-morbidities?	clone of a plasma cell or B lymphocyte. Plasma cell dyscrasias are produced as a result of abnormal proliferation of a monoclonal population of plasma cells that may or may not secrete detectable levels of a monoclonal immunoglobulin or immunoglobulin fragment (paraprotein or M protein). So it's almost the same, however, there are some differences: If a disease is caused by a monoclonal line of plasma cells, derived either from a malignant clone(s) or from a nonproliferative population of cells, the condition is called plasma cell dyscrasia. In some cases, monoclonal gammopathies may occur as a result of abnormal B cells, which have not yet developed into plasma cells. This type of gammopathy is seen in leukemia or lymphoma [Attalman M, Levinson SS. Understanding and Identifying Monoclonal Gammopathies. Clinical Chemist. 2000; 46 (8):1230–1238]. We think that both of MG and PCD require a biopsy. It would so kind from you to explain to us what is the difference between MG and PCD to improve more the quality of the manuscript? d. you are right about this point, however, this is the story of the work. At first, the aim of the work was only to describe features of PCDs in patients requesting electrophoresis and immune-electrophoresis and we should to delete any double technique. But in the work we observed that patients didn't followed-up their states by biological tests. This is why we have added the idea. Therefore, the goal becomes to highlight the importance of these tests to define the type of PCDs besides biopsy results. The real problem is that because of poverty or lack of knowledge, patients don't know the gravity of their illness, so they give up the pursuit of diagnosis or even treatment. This is the answer for your
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		question number (e). In conclusion, we spoke about this idea [It is also important to mention that biological tests weren't performed by all members of our cohort, probably because of financial constraints, that limit the opportunity for monitoring of their disorders progression] So we thought that this manuscript was the opportunity to highlight that problem. Maybe, our country could find solutions to solve it by many ways.
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Minor REVISION comments	(a) The manuscript is froth with several grammatical errors, the reviewer has tried to correct some, however someone proficient in English language needs to go through the manuscript. (b) Authors should use the mean instead of the median values (c) Prognostic indices in myeloma include a beta 2 microglobulin level of less than 3.5mg/dL, not 2.4. (d) Authors should carry out necessary statistics to determine any associations between the parameters investigated	For your question: Were these patients already diagnosed using more than 10% plasmacytosis in the bone marrow? We don't really know; because clinicians send sera of patients, or even patients came to laboratory to have tests. In both cases we don't have information whether patients have or not plasmacytosis in the bone marrow. This is why we couldn't also give a precise diagnosis for those gammopathies. (a). Some grammatical errors were corrected. Thank you for your contribution. (b) you are right. Median was changed by mean. Thank you. P.S. for age it's a mean not a median (median is 56 years ; mean is 54.7 years; SD is 10.7 years) (c) Values of β2-m were corrected into 3.5 mg/l. (d) Statistics were undertaken by using Pearson's r measures. Thus, the associations between total protein level above or equals to 80 g/l and monoclonal paraprotein concentration above 20 g/l; and between monoclonal component (MC) and serum β2m levels were strong; A moderate relationship between albumin levels and calcium concentrations; between low levels of albumin and high serum monoclonal protein levels and between low levels of albumin and anaemia. However, the association between high β2-m levels and low albumin (or β2-m levels and calcium concentrations) was not proved, maybe it's due to the small number of patients performing β2-m test. These ideas were added in manuscript.
Optional/General comments		