



SDI FINAL EVALUATION FORM 1.1

PART 1:

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	Research paper

PART 2:

FINAL EVALUATOR'S comments on revised paper (if any)	Authors' response to final evaluator's comments
Abstract This has not been well articulated and was not covered by the span of the study - Authors want to assess patients compliance to follow up and also compare results of results from various institutions in Morroco. In the concluding portion, authors made reference to suitability of certain investigative modalities – this was not and cannot be ascertained from this study. Introduction-See corrections on document Methods – See corrections on document Discussion- Needs to be re-written	We would like to thank you deeply for your contribution and for advises: In abstract , this following idea was removed: “Our study showed that the majority of patients didn’t follow up the progression of their monoclonal gammopathies by biological tests” (page 1). In introduction, the idea talking about diagnosis was written like follow: “Thus, the bases of the diagnosis are the presence of bone marrow plasmacytosis and the detection of an abnormal monoclonal paraprotein in the serum and/or urine, by means of electrophoresis and immuno-electrophoresis”. (page 2) Because one of the first step to detect a PCD besides bone marrow biopsy is leading a serum or urine protein electrophoresis as was reported by Mayo and Johns. “the first step in the laboratory evaluation of a patient with a suspected plasma cell dyscrasia has traditionally been electrophoresis of serum and urine” [Mayo MM, Johns G S. Serum free light chains in the diagnosis and monitoring of patients with plasma cell dyscrasis. Herrera GA (ed). The kidney in plasma cell dyscrasis. Contrib Nephrol. Basek. Karger, 2007, 153 pp 44 -65]. In material and methods The followed idea “ the choice of these two techniques was based on the necessity for detection of monoclonal gammopathies affection “ was written like this: One of the first steps in the laboratory evaluation of a patient with a suspected PCD has been electrophoresis of serum or urine. Thus, only patients who had a gamma or beta (rarely alpha 2) monoclonal peak and a monoclonal immunoglobulin demonstrated by urine or serum protein electrophoresis and immuno- electrophoresis, respectively, were retained. (pages 1 and 2) In discussion some ideas were removed. Like “Ideally, to the best of our knowledge, no epidemiological study has explored the detection of MGUS in Moroccan population probably could increase the life expectancy among patients with PCD”. Authors focus on PCDs and not monoclonal gammopathies in the whole text as you have advised. In discussion concerning the relationship between B 2 m , albumin and monoclonal component, some ideas were removed and others were re organized. You are right CRAB distinguish between MM and asymptomatic myeloma and between MM and MGUS. The reference below explain this : The current diagnostic criteria for MGUS and myeloma, require measurement of the bone marrow plasmacytosis, M-protein and the presence of end organ damage defined by the acronym “CRAB”.² This mnemonic refers to organ damage caused by the malignant plasma cell proliferation or by the pathologic M-protein: C = hypercalcaemia; R = renal impairment; A = anaemia; B = bone lesions. If any of the CRAB criteria are present, then the diagnosis is symptomatic myeloma irrespective of the level of the M-protein or marrow plasmacytosis. If the bone marrow plasma cell percentage is ≥10% or the M-protein is ≥30 g/L and there is no CRAB, then the diagnosis is asymptomatic myeloma. If the bone marrow plasma cell percentage is < 10%, the M protein is < 30 g/L and there is no CRAB, then the diagnosis is MGUS [Peter Mollee, Current Trends in the Diagnosis, Therapy and Monitoring of the Monoclonal Gammopathies. Clin Biochem Rev Vol 30 August 2009. 93-103]. These followed ideas were removed :”As was discussed above, high concentrations of calcium, as well as high β2-m and low albumin serum levels, could be considered as prognostic factors for PCDs” (page 9); “It was noteworthy that without having results of bone marrow biopsy and the lack of performing biological examinations in the current study, the type of PCD couldn't be determined. For this reason, the diagnostic of each disorder requires the performance of bone marrow biopsy, clinical investigations, radiological studies and laboratory tests”. However, this latter idea was indicated in limitations of the study to avoid repetition.