Response to Reviewers

Dear Editors and Reviewers:

Thank you for your letter and for the reviewers' comments concerning our manuscript entitled "Development of Dilated Cardiomyopathy with a Long Latent Period followed by Viral Fulminant Myocarditis" (Manuscript NO: 80364, World Journal of Clinical Cases). All these comments are valuable and very helpful for revising and improving our paper. We have studied the comments carefully and have made corrections that we hope will be met with approval. All significant changes are highlighted in yellow in the revised manuscript. In addition, we rearranged the contents, to avoid confusion of final diagnosis. Our revised manuscript has been edited by a professional editorial service.

The part of 'OUTCOME AND FOLLOW-UP' was restricted as only the latest follow-up status. Of the previous version, one year and the 8th year follow-up description is the main clinical presentation toward the final diagnosis, 'a long remission period after viral fulminant myocarditis'. Therefore, we rearranged the part of 'OUTCOME AND FOLLOW-UP' to 'FURTHER DIAGNOSTIC WORK-UP'. We believe this rearrangement will help readers understand.

The main corrections in the paper and the responses to the reviewer's comments are shown below.

Answering Reviewer #1

Name of journal: World Journal of Clinical Cases

Manuscript NO: 80364

Title: Development of Dilated Cardiomyopathy with a Long Latent Period followed by Viral Fulminant Myocarditis

Reviewer's code: 05927046

Reviewer's Country/Territory: China

Point-by-point responses to the reviewer's comments are as follows:

Response to comment: Dilated cardiomyopathy is sometimes associated with genetics, so was this patient tested for genetics? Are genetic factors such as mutations ruled out? If genetic factors are excluded, the patient's dilated cardiomyopathy may be more closely related to fulminant myocarditis.

Response: Dear reviewer, we thank you for your valuable suggestion. We completely agree with you that there have recently been advances in genetics associated with DCM. However, our case allegedly had no family history of DCM, and gene screening for cardiomyopathy was not available at our facility. Furthermore, at that time, we assumed that her history of myocarditis was very clear, so we did not anticipate that her final DCM status would be one of genetic cardiomyopathy. In addition, even if the gene test was available, the patient could not afford it. We further described those limitations in paragraph 3 of the "DISCUSSION" section.

Answering Reviewer #2

Name of journal: World Journal of Clinical Cases

Manuscript NO: 80364

Title: Development of Dilated Cardiomyopathy with a Long Latent Period followed by Viral Fulminant Myocarditis

Reviewer's code: 03639986

Reviewer's Country/Territory: China

Point-by-point responses to the reviewer's comments are as follows:

Response to comment: 1. NT-proBNP/BNP is a biomarker of heart failure. However, this indicator cannot be found in the article, please provide the value of NT-proBNP/BNP.

Response: Thank you for your important comment. We have added the patient's initial BNP level at first presentation. The revised details are shown in the "CASE PRESENTATION" section and the "laboratory examinations" section.

Response to comment: 2. On the first visit to the emergency department, why are liver functions, electrolytes and blood routine tests abnormalities, other than that, no abnormal findings including cardiac enzymes were found? Are cardiac enzymes always normal during the hospitalization.?

Response: Thank you for your helpful comments. She presented with pulmonary edema due to heart failure. Her highly elevated liver enzymes rapidly improved with diuretic therapy. As her liver ultrasonography showed no specific findings other than mild fatty liver, hepatic congestion was considered the main cause of her abnormal liver function. Mild hypokalemia was initially thought to be the result of a sustained general edematous condition and its associated poor oral nutrition. (The revised details are shown in the "Imaging Examinations" subsection of the "CASE PRESENTATION" section and the "FURTHER DIAGNOSTIC WORK-UP" section, paragraph 1.)

Initial and follow-up cardiac enzyme levels remained in the normal range until the first discharge but were elevated when the patient was readmitted under CPR (described in paragraph 4 of the "FURTHER DIAGNOSTIC WORK-UP" section). The cardiac enzyme levels seemed unusually low for acute myocarditis. In this case, the cardiac enzyme levels were elevated at follow-up, which we believe indicated myocarditis. However, some reports have suggested that cardiac biomarkers are elevated in about one-third of patients

with acute myocarditis, and normal cardiac enzyme levels cannot rule out fulminant myocarditis.

Response to comment: 3. The latest imaging data is in September 2020. Please provide the latest follow-up data. The myocarditis cannot be ruled out on the second hospitalization.

Response: Thank you for your helpful suggestion. The patient's latest imaging work-up was done in March 2021 and did not include M-mode echocardiography, so the results are not attached.

Compared to the image of September 2020, which was included in the manuscript, biplane EF was slightly improved but still had a low EF (described in paragraph 3 of the "OUTCOME AND FOLLOW-UP" section).

As mentioned in paragraph 2 of the "DISCUSSION" section, because the patient showed gradual aggravation rather than acute deterioration, we thought that she had chronic HF rather than recurrent myocarditis.