Dennis A Bloomfield, FACC, FACP, FRACP, FRCP (Hon), MD, MRCP, Professor
Editor-in-Chief
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Dear Dr. Bloomfield,

We thank the reviewer for pointing out the issues and agree with the reviewer. We have revised the manuscript, based on the helpful critique form the reviewer. We make a point-to-point response to the issues as follows. The revised parts are in bold for easy identification.

Issues and responses

1. Issue: Absence of report of findings on physical examination

Response: We have revised the part providing findings on physical examination.

On physical examination, the patient was pale, awake, alert, and responsive to questions and in acute respiratory distress. **There was some skin petechial, indicating a bleeding tendency, but there was no skin rash, oral ulcers, alopecia and enlarged lymph nodes.** Her heart rate was 140 bpm, blood pressure was 112/70 mmHg with norepinephrine continuously pumped (0.8 μg/kg per min), respiratory rate was 42 breaths per minute, and temperature was 37.6 °C. The oxygen saturation remained at 80% on room air and increased to 94% on a high-flow nasal cannula with FiO2 of 40%. **These findings suggested severe circulation shock and respiratory failure.** Heart auscultation showed low heart sounds **without murmurs**, and there were crackles over both lung fields, **indicating heart failure associated with pulmonary edema or pneumonia. Her abdomen was soft and not tender, and the liver and spleen were not palpable. She had joint line tenderness in both knees** and mild edema in both lower extremities.

2. Issue: Failure to address SGPT elevation

Response: We have revised and addressed SGPT elevation.

Alanine aminotransferase (98 IU/L) and aspartate aminotransferase (301 IU/L) were increased**, that could be attributed to liver congestion induced by heart failure.**

3. Issue: Failure to address notation that lupus was a serologic diagnosis

Response: We have revised and addressed the notation.

According to the 2012 Systemic Lupus International Collaborating Clinics (SLICC) classification criteria[1], lupus is a serologic diagnosis associated with a clinical diagnosis. The SLICC criteria require at least one clinical and at least one immunologic criterion for a total of four. The patient had thrombocytopenia, knee pain with morning stiffness, positive ANA, hypocomplementemia, sever heart failure and consolidation in the lung with leukocytosis, thus the final diagnosis of the presented case was cardiogenic shock induced by fulminant lupus myocarditis with coexisting community-acquired pneumonia.

4. Issue: Absence of consideration of differential diagnosis of the findings and why not Sjogren syndrome.

Response: We have revised and addressed the differential diagnosis and why not Sjogren syndrome. In our case, Schirmer paper-strip tear tests showed normal results, and the patient had no symptoms of dry mouth and dry eye. Sjogren syndrome was unlikely to be the cause in this case, and the patient and her family refused the labial gland biopsy due to worrying about this invasive test.

Further diagnostic work-up

Viral myocarditis, one of the most common causes of cardiogenic shock in the young people, was considered in the primary differential diagnosis. However, the patient had no previous medical history of upper respiratory tract infection and further virological serum tests, such as influenza A and B, enterovirus, adenovirus and cytomegalovirus, were negative. Therefore, viral myocarditis was excluded as the cause of this case. SS-A antibodies and SS-B antibodies were positive, so primary Sjogren's syndrome was considered in another differential diagnosis. **The patient had no symptoms of dry mouth and dry eye and further Schirmer paper-strip tear tests were normal, with 12 mm/5 min and 13 mm/5 min for both eyes. Based on the 2016 American College of Rheumatology and European League Against Rheumatism classification criteria for primary Sjogren's syndrome[2], it was unlikely to be the cause in this case.**

We appreciate very much your kind consideration for publication of our manuscript and look forward to hearing from you at your earliest convenience.

Yours sincerely,

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2 **Shiboski CH**, Shiboski SC, Seror R, Criswell LA, Labetoulle M, Lietman TM, Rasmussen A, Scofield H, Vitali C, Bowman SJ, Mariette X, International Sjögren's Syndrome Criteria Working Group. 2016 American College of Rheumatology/European League Against Rheumatism Classification Criteria for Primary Sjögren's Syndrome: A Consensus and Data-Driven Methodology Involving Three International Patient Cohorts. *Arthritis Rheumatol* 2017; **69**: 35-45 [PMID: 27785888 DOI: 10.1002/art.39859]