June 9, 2013

Dear editor and reviewers,

Thank you all for your positive comments. We have now updated our manuscript according to your valuable suggestions and we think that it has now improved significantly.

Please do find a point-to-point response to each reviewer's comments.

We believe that you will now find our paper suitable for publication to World Journal of Cardiology.

Title: Non-coronary myocardial infarction in myasthenia gravis: case report and review of the literature

Authors: Panagiotis Zis, Stavros Dimopoulos, Vasiliki Markaki, Antonios Tavernarakis, Serafim Nanas

Name of Journal: *World Journal of Cardiology*

ESPS Manuscript NO: 3265

02451519

Thank you for your comments. The manuscript has now been revised by a native speaker.

01919991

Thank you for your comments. We have improved the manuscript with more detailed medical history, especially regarding other possible risk factors.

We have added in our discussion that a possible interaction between other drugs is unlikely as the only medications added to our patient's regime were pyridostigmine and prednisolone and the patient was stable on carvedilol before her admission.

The manuscript has now been revised by a native speaker.

02454979

Thank you for your comments.

We have now added in our discussion a paragraph explaining that we believe that the myocardial infarction was because of coronary vasospasm.

Our laboratory measures the titer of anti-achr antibodies, in nM (which is nmoles/L). We have changed nM to nmoles/L to make this clearer. As we also show the normal values, the reader can now easily see that our patient had a titer 270 times higher to compared to highest normal.

We have added the relevant reference in page 7- paragraph 2.

We have now added a follow up ECG where all changes have resolved.

We have now added units for Y Axis in figure 2

The manuscript has now been revised by a native speaker.

02457919

Thank you for your valuable comments.

Of course it is difficult to attribute the MI to pyridostigmine, and we have made this clearer in our discussion. We think that the time interval between initiation of the treatment and the MI is really interesting and based on that we have set a hypothesis that there may be a link between the two events.

Indeed pulmonary embolism cannot be accurately ruled out based only in arterial gases and D-dimers, however we performed a spiral chest CT three weeks later, which was normal. We have added this to our limitations.

As the patient did not immediately consent to the coronary angiogram, the latter took place a few days later. We have also mentioned that in our limitations.

When we reviewed the manuscript again, we noticed that accidentally we have written that the patient was on a calcium antagonist, when she was on carvedilol, as we mention in the revised manuscript. There was no change of the treatment during her hospitalization, apart from the initiation of pyridostigmine and prednisolone and the patient was stable on her anti-hypertensive for a significant period prior to admission. We have added this information to our discussion to exclude other possible drug interactions.

Finally, the requested angiographic views of LAD have now been added to figure 3.

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00503412

Thank you for your comments.

00070848

Thank you for your comments.

We have now updated our discussion with the suggested references.

02459482

Thank you for your comments.

Unfortunately we have no ECHO images available. However, an expert Consultant Cardiologist performed the ECHO, and there were no signs of Takotsubo syndrome, as mentioned in the manuscript. We have added this to our limitations.

Yours sincerely,

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