Review of: "[Case Report] Challenging Detection of Latent Tuberculosis in a Patient Undergoing High-Dose Corticosteroid Therapy for Acute Hemolytic Anemia and Rhupus Arthropathy"

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Potential competing interests: No potential competing interests to declare.

The authors highlight an age-old connection between auto-immunity and infection. Specifically, they describe the re-activation of latent Tb in a patient with Rhupus treated with high dose steroids. There are a few issues which I believe merit further commentary:

1 The dose of MTX is stated at 200mg weekly in V1 which is sufficient to cause death, leave alone a macrocytic anaemia. However, I suspect that this is a typo as the WCC and platelets are normal. V2 does not provide the dose of MTX as far as I can see, but it should do so.

2 The use of BAL was pivotal in this case and provided material for the diagnosis. I think this is worthy of greater emphasis in the discussion, given clear evidence of necrotising change in the upper lobe on HRCT. The use of PCR to identify Tb organisms in BAL fluid deserves to be highlighted in your recommendations and is readily referencable.

3 Which diagnosis was made first - Rhupus or Tb? And on what basis? Without supportive evidence I would be very cautious about claiming that one caused the other. Especially as most physicians would assume that the immunosuppression given to treat the auto-immune disease reactivated latent Tb unless there was clear evidence to the contrary?

4 Is the term ‘acuity’ used in an entirely appropriate context?

5 Reference to the historic linkage between Tb and RA may be worth considering. The DRw4 gene is thought to predispose to both conditions and some authorities have suggested this as the reason for one of the plagues of ancient Egypt, surmising that the natives had much higher susceptibility to Tb than did the Jewish people who were genetically very different.