OPEN PEER REVIEW

Open Peer Review (OPR)

As a new feature for progressing towards transparency, we decided to open a new window for all of our editors as well as authors titled "**Open Peer Review**". We hope by this new facility, our reviewers will be more motivated and authors will be more satisfied with the review process. We believe that publishing our peer review reports could make a transparent and clear environment for all our efforts within a journal, but not all reviewers tend to publish their comments.

What is "Open Peer Review" process?

An "Open Peer Review" process is making the details of all review process (including reviewers, associate editors, and EICs comments) as "Public" as it is agreed by EIC, Authors, and reviewers.

Advantages of "Open Peer Review" process

- More transparency, constructiveness and tactful comments of the peer review process: leads to an increase in the quality of reviews
- More motivations for all involved roles in the review process
- Authors' satisfactions from the review process: Increases honesty between authors and reviewers
- Education of both authors and new students
- Prevents reviewers from following their individual agendas and leading to the detection of reviewers' conflicts of interests

You can find out more at:
https://sites.kowsarpub.com/kowsar/knowledgebase/category/tree.html#opr.html

Journal of Skin and Stem Cell
Article DOI: 10.5812/jssc.102241
Published in: Journal of Skin and Stem Cell: 7(2); e102241

Peer Review Report for "Primary Anetoderma in an Infant: A Case Report From Southeast Asia"

Author(s): Mahmud Ghaznawie, Raymond Widjajahakim, Isaak Effendy

Review Timeline:

Submit Date: 29 Feb 2020
Revised Date: 16 Jun 2020
Accepted Date: 20 Jun 2020

Revision (0)

Here, you can see the **Reviewers**, **Associate Editors** and **EICs'** comments from the beginning to the end of the revision process.

REFEREE: Reviewer | **Revision** (0)

22 Mar 2020

Dear AE,
I read with interest the article titled"Primary Anetoderma in an Infant: A case report on a Southeast Asian"
The manuscript is well written but needs some minor revision.
1- There are some similarities in the text of this manuscript with other publications (marked in the attached file).
- High similarity: Please find the attachment to see the similarity.
- We strongly request you to paraphrase the highlighted parts of your manuscript so as to reduce the level of similarity.
- Please, clearly correct/rephrase all colored sentences in the word file and then upload the revised word file to the journal website (using authorial area). You can find out more about the rules and regulations here.
2- Funding/Support: Not OK
- The authors should state Funding/Support on the journal website: Read more at Here
* Please write meaningful and complete sentences and do not use ambiguous phrases such as "No" or "None Declared".
3- Informed Consent: Not OK
- Authors should obtain written Informed Consent signed by the study participants or patients and should upload a copy of the Informed Consent form on the journal website.

Some samples of Informed Consent can be found here.
Informed consent and other ethical considerations should be mentioned on the journal website or in the text of the manuscript: Read more here
* Please write meaningful and complete sentences and do not use ambiguous phrases such as "No" or "None Declared"
Thanks.

REFEREE: Associate Editor | **Revision** (0) 22 Mar 2020

Dear EIC,
The authors should revise the manuscript based on reviewer comments.
Thanks.

REFEREE: EIC | **Revision** (0) 22 Mar 2020

Dear Author,
The manuscript can be accepted after minor revision.
Thanks.

OPEN PEER REVIEW

Revision (1)

Reply to Reviewers

Ideally, the reviewing process can significantly improve the submitted manuscripts by allowing the authors to take into account the advice of reviewers. Author(s) must reply to all reviewers' comments in a separate Word file, point by point. A "**Reply to Reviewers**" document is submitted along with revised manuscript during submission of revised files, summarizing the changes that the authors made in response to the reviewers' comments. The responses to reviewers' comments specifies how the authors addressed each comment the reviewers made.

You can read the authors' responses to the reviewers' comments in the next page.

Journal Name: Journal of Skin and Stem Cell Ma...

By: Isaak Effendy

As of: Feb 29, 2020 11:39:53 AM
1,633 words - 23 matches - 9 sources

Similarity Index
33%

Mode: Similarity Report

paper text:

Abstract Anetoderma

is an elastolytic disorder characterized by localized area **of flaccid skin, which** may be **depressed, macular or papular; the latter can reflect herniation of the subcutaneous tissue.**

Anetoderma is an elastolytic disorder, categorized with singular or multiple area of macules or papules, which can lead to herniation of the subcutaneous tissue.

Anetoderma is rare, and the incidence is unknown. Primary anetoderma or idiopathic anetoderma occurs when there is no underlying associated skin disease with unknown pathogenesis. It can be classified into two major forms: (a) the Jadassohn-Pellizzari type, and (b) the Schweniger-Buzzi type. Little is known about the specific pathophysiologic processes underlying

anetoderma. The phagocytic destruction of elastic fibers may play a major role in the pathogenesis of the lesions. Our case highlights the incidence of

anetoderma, although the phagocytic destruction of the elastic fibers has been postulated as the major role of the lesions.

primary anetoderma in Southeast Asian adolescent girl with the onset since infancy. Key words: elastolysis, child, macular atrophy, idiopathic anetoderma Introduction The term “anetoderma” is derived from anetos, the Greek word for slack, and derma for skin. Anetoderma

is an elastolytic disorder characterized bylocalized areaof flaccid skin, which may be depressed, **macular or papular**; the latter can **reflect** herniation **of the subcutaneous tissue.1** The

is an elastolytic disorder characterized by macular or papular localized area of flaccid skin, which may be depressed; which can be followed by the herniation of the subcutaneous tissue (1).

condition has been reported under various name, including macular atrophy, anetoderma maculosa, anetoderma maculosa cutis and atrophia maculosa cutis.1,2 Anetoderma is rare, and the incidence is unknown. Several hundred cases have been reported.1,3 Primary anetoderma generally occurs on young adults between 15 and 25 years of age and more frequently in women than men.1 Primary anetoderma or idiopathic anetoderma occurs whenthereisno underlying associated skin disease with unknown pathogenesis.2,3

It can beclassified intotwo major forms: (a) mainly erythema, with preceding inflammatory lesions (the Jadassohn-Pellizzari type), and (b) skin lesions without preceding inflammatory lesions (the Schweniger-Buzzi type).

Commonly, it is categorized into two groups: (a) mainly erythema,with preceding inflammatory lesions (the Jadassohn-Pellizzari type), and (b) skin lesions without preceding inflammatory lesions (the Schweniger -Buzzi type).

This classification is only of historical interest, because these lesions cancoexist inthesame patient; the prognosis and thehistopathology are also thesame.1,3,4 Inthesecondary anetoderma, thelesion occurs onthesame site asanother lesion and

related to various conditions such as infections, inflammatory or autoimmune diseases, drugs, tumours (benign and malignant).6,7 Secondary **anetoderma is**

, with various causes from other conditions such as infections, drugs, tumors (benign and malignant), inflammatory or autoimmune diseases.(6,7). Secondary anetoderma is probably more common than the primary form.(2)We here in report anetoderma case on anadolescent girl with the onset around the age of 7 month, with lesions starting from face and spread to lower abdomen. No family history of anetoderma or other related diseases were reported. Case presentation A 9-year old female, Southeast Asians race with yellow-brown skin, was reported by her mother to have yellowish-white, indented or depressed on same parts and protruding on other parts, round and oval spots; located at chin, neck, front chest, front and back left/right shoulder, and lower abdomen; with no itchiness or ache. Mother reported the lesion started with small concave spot on right cheek when patient was 7- month old. As patient grows, the initial spot disappeared but new and bigger lesions appeared starting from chintolower body.

Several medical interventions hadnot resulted with any improvement. Thepatient was delivered at term (weight 2,8 kg; height 49cm) asthesecondchild. Themother was 26years old when delivering patient, had no history of infection during pregnancy, hadnotick bites reported. The mother had bleeding during the 4th month but medical exam showed normal. First child had died few days after childbirth, 2 years before the patient. The mother had another child at 2-year old with no lesion reported. On clinical examination, patient's general physical condition and mental health conditions were normal. Skin lesions consisted of scattered, yellowish-white to skin- coloured spots.

Lesions varied fromindented to protruding, with the smallest ones at few millimetres in diameter to 30 mmin diameter. The lesions spread from chin to lower abdomen (Figure 1 a-e). No sensory changes associated

with the lesions. Her medical history was unremarkable. The mother denied any previous infection, vaccination, or trauma before the development of skin lesion. No family history of the lesion was reported either.

Laboratory examinations, consisting of complete blood count, urinalysis, blood chemistry including erythrocyte sedimentation rate and liver function tests, were within normal limits.

The results of laboratory tests, consisting of complete blood count, urinalysis, blood chemistry including erythrocyte sedimentation rate and liver function tests, were within normal range. On theskinbiopsy, haematoxylin andeosin-stained showednormal epidermis tissue. Onthedermis layer, athick,multiple inconsistent breaks of collagen- structure with wide gap/spaces was observed. (Figure 2a). Verhoeff-van Gieson stained section showed a dermis layer with loss/diminished of elastic fiber. Based on clinical and pathological findings, the patient was diagnosed as Schweninger-Buzzi type primary anetoderma. (Figure 2b).

Discussion The term " was first reported by Schweninger and Buzzi in 1891, and anetoderma By Jadasson in 1892. Sincethen, many cases of anetoderma have been reported under different terms.[1,8] The term "macular atrophy" has been mainly used because of the clinical features, while it could be confusing because the term has also been used in other conditions showing dermal atrophies.

Schweninger and Buzzi coined the term anetoderma in 1891, and then followed by Jadasson in 1892 as well as many other different terms (1,8). One of the term, "macular atrophy", could be confusing due to possibility of mix up with other conditions showing dermal atrophies (8).

8 Here, we reported a case of Schweninger-Buzzi type primary anetoderma with the age of onset at 7

month old. To our knowledge, this is the reported secondcaseof

month old. From our literature research, we believe this is the first case of this diagnosis reported on a South East Asian infant who had no family history or heredity. Previously, cases

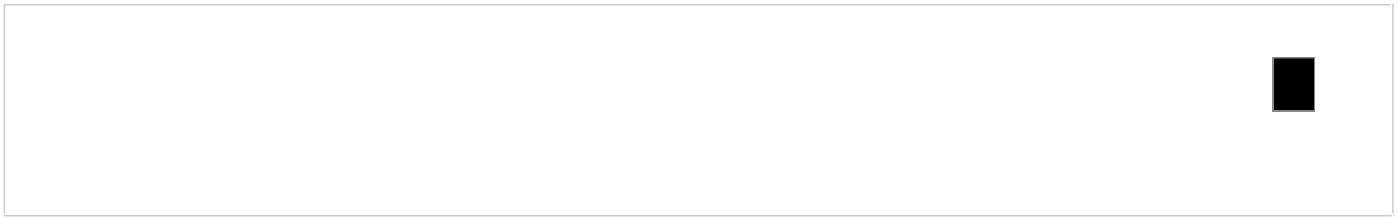
this diagnosis on an infant. Previously, cases of primary anetoderma in infants had been reported at 1 month and 5 months.9 Then, infemale babies born premature twins (infamily 8). Infants aged 4 months with afamilial historyintheir parents (in family 11).7,8 And in premature babies, possible due to the application of transcutaneous oxygen monitoring is also called iatrogenic anetoderma. 4 The most common sites for these asymptomatic lesions are the chest, back, neck, and upper extremities.3 Less commonly, the lesions distributed

in the face.2,5,8 The scalp, the palms, the soles, and the mucous membranes are usually spared.2 Little is known about the specific pathophysiologic processes underlying anetoderma.10

There has been little evidence **delineating exactly how anetoderma develops and why similar histopathologic** features **canpresent withdifferent clinical features, such asprotruding or indented skin phenotypes.**

There has not been a conclusive theory on how anetoderma develops and why similar histopathologic yet different clinical characteristics exist (5).

5 Elastin, the main component of elastic fibers.



Elastin, the main component of elastic fibers, with high content of hydrophobic amino acids and strong cross-links causing elastin as one of the most resistant and durable protein in the human body. Transmission

Transmission electron microscopy examination and scanning electron microscopy evidencing the fragmentation, granular degeneration and reduction of elastic fibers. 11

In primary anetoderma, the phagocytic destruction of elastic fibers may play a major role in the pathogenesis of the lesions, as demonstrated by the presence of fragmented elastic fibers phagocyted by macrophages in the lesion border. An in vitro study has demonstrated an altered balance between matrix metalloproteinases (MMP 2 and MMP 9) and tissue inhibitors of metalloproteinase (TIMP) in favor of elastolysis.

Currently, the phagocytosis of elastic fibers has been hypothesized as a major role in the pathogenesis of the lesions in primary anetoderma. This was due to the presence of fragmented elastic fibers, broken by macrophages in the lesion border. An study by Ghomrasseni et al. has observed changes in the expression level of several metalloproteinases (MMP2 and MMP 9) and tissue inhibitors of metalloproteinase (TIMP in favor of elastolysis) (12). Immunologic mechanisms…..

Immunologic mechanisms may also play a role, as it can be associated with various systemic conditions, primarily antiphospholipid antibodies. Anetoderma on preterm infant has been reported but not investigated as a primary focus. The non

-production of elastic fibers in the dermis has been suggested related to prematurity.

It has been suggested that the low level of elastic fibers in the dermis is related to the prematurity while the pathogenesis for familial anetoderma is still unclear (2,3,5,7).

The pathogenesis for familial anetoderma is still unclear.2,3,5,7 Rarely, anetoderma can be acquired genetically.10 Kim et al.

examined the clinical and histopathological correlations of different types of anetoderma. Anetoderma lesions showed a variable pattern of loss and fragmentation of elastin in the dermis depending on the stage and the severity of the disease.

Elastic fibers consist of elastin andmicrofibril,both of which are possible targets of autoantibodies.

Kim et al, examined the clinical and histopathological correlations of different types of anetoderma (5). Variable pattern of loss and fragmentation of elastin in dermis can change depending on the stage and severity of the disease. Elastic fibers which consist of elastin and microfibril, could be a target of antibodies for immunohistochemistry tests . In a test, the lesion indented decreased elastic tissue only in the upper dermis. The pattern of elastin destruction did not differ between the protruding, but the destruction of the protruding was greater than the indented type and could be due to the extended period of the disease; thus, it is speculated that the protruding type is a more advanced stage of anetoderma (5).

Result from immunohistochemistry showed

an indented lesion showed decreased elastic tissue only in the upper dermis. The pattern of elastin destruction did not differ between the protruding type and the indented type. The degree of elastic fiber destruction was greater in the protruding type than the indented type.

Patient

with protruding type lesions showed a longer disease duration and more severe loss of elastin than patient with indented type lesions,

which may suggest an evolution of indented lesions into protruding lesions.

From these findings, one could speculate that protruding type is a more advanced stage of anetoderma.

5 In routinely stained section

Hematoxylin and Eosin and Verhoeff-van Giesonstain,there was no epidermal change from the lesionand the collagen

In routinely stained section Hematoxylin and Eosin and Verhoeff-van Gieson stain, no epidermal change from the lesion was detected and the collagen within the dermis of affected skin appears normal and was

within the dermis of affected skin appears normal and was similar tothat of the controls. The predominant abnormality (as revealed by

elastic tissue stains)is afocal, more or less complete loss of elastic tissue in the papillary and/ or reticular dermis. There are usually some residual abnormal, irregular, and fragmented elastic

fibers.1,5 According to those tissue stain, the dominant abnormality in the papillary and/or reticular dermis is focal, complete loss of elastic tissue with some residual, fragmented elastic fiber (1,5).

Fitz et al.3 suggested to differentiate anetoderma from other disorder of elastic tissue, by categorizing elevated lesions (secondary anetoderma, acne scars, keloids, nevus lipomatosus superficialis, papular elastorrhexis, connective tissue nevi) and depressed lesions (secondary anetoderma, glucocorticoid-induced atrophy, acne scars). No effective treatment is available for

anetoderma. Treatment should be directed against underlying disease or infections.

anetoderma. Treatment should be focused on the underlying disease or infections (2,4). Appropriate….

2,4 Appropriate treatment of the inflammation underlying condition might prevent new lesions. Topical medication using epsilon- aminocaproic acid (an antifibrinolytic) and/or systemic administration such as aspirin, dapsone, phenytoin, penicillin G, vitamin E, vitamin C, inositol niacinate and oral colchicine.2,12 Surgical excision may be useful for limited lesions that cosmetically objectionable. Ablative and non-ablative fractionated lasers have shown some improvement in limited case.1,3

,3 The lesions remain unchanged throughout life, and new lesions often continue to develop for many years.2,4The

From observations, anetoderma remains consistent throughout life, and new lesions often continue to progress for years (2,4). The presence or……

presence or absence of clinical inflammation at the onset of the disease is not related to prognosis.1 In Summary, we report a case of primary anetoderma with the onset of 7

-month old infant. To our knowledge, this is thesecond**reported**

In Summary, we report the first reported case of primary anetoderma in a South East Asian female with the onset during infancy but with no family history of the disease. The location of rare facial lesions….

case in primary anetoderma in infants and the location of rare facial lesions which later disappeared and re-appeared on lower body as patient ages.

Therefore, it will be necessary to observe our patient for the future development of any of these **abnormalities.**

…..lower body as patient ages. Future studies may include the follow up of the patient for further disease progression as well as further investigation of the prevalence of this disease in this population.

LEGENDA: Figure 1 (a-e): Skin lesions consisted of scattered, yellowish-white to skin-coloured spots, which varied from indented to protruding, with thesmallest ones at few millimetres in diameter to 30 mm in diameter. The lesions spread from chin to lower abdomen. Figure 2b: Verhoeff-van Gieson stained section showed a dermis layer with loss/diminished of elastic fiber. Based on clinical and pathological findings, the patient was diagnosed as Schweninger-Buzzi type primary anetoderma

sources:

1 174 words / 10% - Crossref
Jung Eun Kim, Ki Min Sohn, Young Jun Woo, Kwan Ho Jeong et al. "A Clinicoimmunohistopathologic StudY of Anetoderma: Is ProtrudingT ype More Advanced in Stage Than Indented Type?", Journal of Immunology Research, 2016

2 109 words / 6% - Internet from 17-Dec-2013 12:00AM
www.jle com

3 58 words / 3% - Crossref
Maiko Fukayama, Tomomitsu Miyagaki, Kaname Akamata, Savaka Suzuki, Mariko Tanaka, Shinichi Sato. "Japanese familial anetoderma: A report of two cases and review of the published work", The Journal of Dermatology, 2018

4 53 words / 3% - Internet from 17-Sep-2012 12:00AM
www.dermatology.org.uk

5 52 words / 3% - Internet from 05-Sep-2014 12:00AM
www.bioline.org.br

6 40 words / 2% - Internet from 12-Aug-2017 12:00AM preview-bmcdermatol.biomedcentral.com

7 38 words / 2% - Crossref
H-J. Yu. "A case of primary anetoderma in an infant", British Journal of Dermatology, 10/4/2007

8 25 words / 1% - Internet from 07-Feb-2020 12:00AM

9 10 words / 1% - Internet from 16-Mar-2019 12:00AM
onlinelibrary wile .com

OPEN PEER REVIEW

Revision (1)

Here, you can see the **Reviewers**, **Associate Editors** and **EICs'** comments from the beginning to the end of the revision process.

REFEREE: Reviewer | **Revision** (1) 20 Jun 2020

Dear AE,
The study is reviewed carefully. According to comments and revisions by the author, this manuscript is accepted.
Thanks

REFEREE: Associate Editor | **Revision** (1) 20 Jun 2020

Dear EIC
Based on the authors' answers to the reviewers' comments, the reviewer(s) have recommended publication.
Kind regards.

REFEREE: EIC | **Revision** (1) 20 Jun 2020

Dear Author,
The document is reviewed carefully by the reviewers. According to their comments and your revisions as requested, this manuscript is accepted.
Thanks.