

28 December, 1999

Clinical Chemistry and Laboratory Medicine
attn. Dr. Marek H. Dominiczak
Walter de Gruyter GmbH & Co. KG
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Dear Dr. Donimiczak:

Thank your for your letter concerning my paper. Enclosed are revised four copies of my article entitled "Macro creatine kinase type 1: a clinically significant marker?" It has been modified in accordance with the referee's comment. The revision was done in the second paragraph, which was underlined as follows.

A 70-year-old man had muscle ache in the vicinity of the four limbs for some years. He had neither a past history of diagnosed musculoskeletal disease such as myositis, heart disease, autoimmune disease, malignancies or a family history of such diseases. Although he had received occasional treatment with non-steroidal anti-inflammatory drugs, satisfactory efficacy on his pain had not been obtained. His other physical findings were all normal. A serum CK rise (589IU/L; reference interval 50-210 IU/L) was revealed in ambulatory treatment, necessitating a CK isoenzyme test, which yielded an abnormal band of CK type 1 (between MB and MM bands) in electrophoresis. At the isoenzyme test, the determinations of CK-BB, MB and MM were 0, 16 and 525 IU/L, respectively. Three autoimmune antibody tests (rheumatoid factor, anti-Jo1 and anti-DNA) yielded negative results and other biochemical parameters were all within reference ranges. Subsequently, an abnormal band of CK type 1 and a slight increase of total CK (220-280IU/L) has persisted along with his chronic pain for some months. However, he has refused further examinations such as electromyogram and muscle biopsy, and a referral to specialists to the present time.

Sincerely yours,

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