Author's response to reviews

Title: Percutaneous septal ablation for left mid-ventricular obstructive hypertrophic cardiomyopathy: a case report

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Please, provide complete invasive pressure measurements at rest conditions after ablation (similar to data before intervention i.e. LV apex, LV outflow tract and aortic pressures).
Pre and post-procedural invasive pressure measurements were provided as Figure 2.

The area of echocontrast deposit is not clearly visualized in figure 2A.
We can not add more clearly image that shows echocontrast deposit. This image is the clearest one in our archive.

Specifically the actual distribution of the cannulated septal artery is still not well described.
The first septal branch was dominant (diameter: 2.1 mm) and showed prominent septal myocardial distribution (Figure 1C). The distance between the left anterior descending coronary artery ostium and the origin of the first septal branch was 24.4 mm. Other distal septal branches were very small (their diameters were <0.5 mm).

Their explanation that the early systolic sound is due to atrial contraction is incorrect. The so called "early systolic sound" based on their response may well be a fourth heart sound. The term "early systolic sound" has been changed as fourth heart sound in the manuscript.

The use of echovist in septal ablation has still not been commented upon - total AV block and VF have been reported with its use, and application in the systemic arterial circulation is neither approved nor can it be recommended as a routine approach. As said before, Levovist is appropriate echo contrast agent for septal ablation.
The statements that "Although severe arrhythmias were not seen in our case, total AV block and ventricular fibrillation may occur with application of echovist in the systemic arterial circulation. Therefore, levovist is appropriate echo contrast agent for septal ablation" have been added in the discussion section.

Furthermore, the correlation between ablation site and echo contrast depot during the intervention is still not clear from the images provided. The authors did add, as suggested, an additional figure to show that the target area in the mid-septum was really hit - however, the statement that local contractility was normal is certainly not true - even on the still frame a local asynergy appears to be present.
We can not add more clearly image that shows echocontrast deposit. This image is the clearest one in our archive. The statement "local contractility was normal" has been removed from the manuscript.

The discussion should make clear that septal ablation in MVO-type HCM, in contrast to the "classical" subaortic type of obstruction, is still an experimental therapy that should be undertaken on a case-by-case basis only.
The statements that "Septal ablation in MVOHC is not classical and wide accepted treatment in contrast to the subaortic type LV obstruction. Possible complications and unknown long-term effects require careful patient selection as well as experience in interventional cardiology and hypertrophic cardiomyopathy" have been added in the discussion section.