Author's response to reviews

**Title:** Management of gastro-bronchial fistula complicating a subtotal esophagectomy: Case report

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**Author's response to reviews:** see over
Dear Sir/Madam,

Many thanks for the reviewers’ comments which we have found very helpful. A number of points were raised by two of the reviewers, Dr Nozaki and Dr Bona, which we have addressed. We outline these points and our response to these below.

**Reviewer: Isao Nozaki**

**Minor Essential Revisions**

(1) The anastomosis between cervical esophagus and gastric tube is usually located in the upper mediastinum, and is far from the left main bronchus. The CT images in the Figure 2. have two arrows that points two different places: One points near the neck anastomosis, the other points the left main bronchus. How many fistulae did the patient have? If he had one, is the fistula very long? A gastro-bronchial fistula is usually formed side to side between the two organs very closely. The authors should clarify this unclear description by a new figure or comments.

*There was just one fistula, which as Dr Nozaki suggests, was a long fistula between a true cervical esophagogastric anastomosis and the left main bronchus. We have emphasized this point by amending the figure legend to Figure 2 to read: “CT thorax showing the mediastinal collection of air with a single, long fistulous communication between the esophagogastric anastomosis located the neck (A) and the left main bronchus (B).”*

(2) A formation of gastro-bronchial fistula after a subtotal esophagectomy is usually fatal due to respiratory dysfunctions. However the patient recovered from it by the conservative therapy without pulmonary complications. The authors should speculate reasons in Discussion why they could successfully treat it with no interventions. I speculate one of the reasons is that the fistula was long enough to close itself (See comment #1).

*We have addressed the reasons for a successful outcome to a conservative approach in this case, borrowing from the helpful comments of Dr Pramesh, and have included the following line at the end of the discussion section: “To our knowledge, this is the first report of successful conservative management of a gastro-bronchial fistula complicating a subtotal esophagectomy. Our experience would suggest that in very carefully selected cases where bronchopulmonary contamination from the fistula is minimal or absent, there is no associated inflammation of the tracheobronchial tree and the patient is stable from a respiratory point of view without evidence of sepsis, there may be a role for a trial of conservative management.”*

(3) The authors described that the patient was managed with respiratory support after the detection of fistula until it closed. What does the respiratory support mean? Intubation with respirator? They should clarify this point.

*We have clarified this point by amending the relevant sentence to read: “He was managed conservatively with antibiotics, enteral nutrition via a jejunostomy, and non-invasive respiratory support in the form of humidified oxygen via face mask and chest physiotherapy”.*

**Discretionary Revisions**
The title should be subtotal esophagectomy or transthoracic esophagectomy instead of near-total esophagectomy. 

*We have taken account of this point and have accordingly amended the title of the paper to “Management of gastro-bronchial fistula complicating a subtotal esophagectomy: Case report.”*

(2) Although the authors detected no evidence of leakage or abscess near the anastomosis in the CT images that was performed the fourth postoperative day, they had better show some of the images near the anastomosis as a new figure.

*There is no abnormality on the CT in question as we have alluded to in the text and as such, we feel that these images would not add to the value of the paper.*


*There are a number of other reports in the literature of gastro-bronchial fistula occurring after esophagectomy, however, we feel that an exhaustive review is beyond the scope of our paper and that our discussion extensively discusses the experience as relevant to our case.*

**Reviewer: Davide Bona**

1. Did you perform a radiographic swallow study before postoperative day 14? 
   *We did not.*

2. In the Case Report section you state that endoscopy revealed a healthy gastric tube and that a tiny area of granulation tissue was seen in the anterior portion of the anastomosis. Did you try to inject methylene blue to demonstrate the presence of a communication between the assumed leak and left main bronchus? Do you have any endoscopic image of the anastomotic site? If yes, I think it would be nice to add that as a figure too.

   *We did not inject methylene blue dye and unfortunately do not have an endoscopic image of the anastomotic site.*

3. (a) Can you please comment separately (A and B) on the two CT scan images (b) eventually clarifying why you assumed that the anastomatic leak was actually a secondary consequence of the bronchial fistula?

   *(a) We have amended Figure 2 and its legend as described above, to take account of Dr Bona’s point. (b) We have amended the relevant sentence in the discussion to read: “Potential mechanisms in this particular case include the rendering vulnerable or ischemic of the tracheobronchial tissue by neoadjuvant chemoradiotherapy, combined with sharp dissection to radically remove all subcarinal nodal tissue, with consequent injury and delayed rupture.” Which we feel clarifies our reason for proposing that the primary problem in this instance was*
bronchial rather than gastric and have described elsewhere that endoscopy revealed a healthy gastric tube.

Reviewer: Mohan Devbhandari

No revisions suggested.

Reviewer: C S Pramesh

No revisions suggested.

We hope the above amendments are to the satisfaction of the editorial committee. We look forward to hearing your response.

Many thanks.

Yours sincerely,

John Larkin.