Dear Mr Zamvar,

This is a covering letter to support the re-submission of my case report to your journal (MS7915541329666320).

I apologise for the delay this was due to me inadvertently deleting your email.

I have made the amendments you requested. I hope they are satisfactory.

Reviewers remarks

1) If reference available to any previous literature on 'Hamburger procedure' please include it.

The reference below has been added in the introduction section 2nd paragraph line 2. Reference 5.


2) Operative details: please provide more details of the operative procedure, with line diagrams, to help readers get a clearer idea of how the placation sutures are placed (specifically where does the needle enter and exit)

An extra figure (Fig 1) has been added. The line diagram. The figure legends have been amended appropriately. The 4th paragraph in the case report section has been changed.

Before

Thirty days after myocardial infarction, she underwent an off-pump ‘Hamburger’ post-infarct VSD repair. The heart was approached through a median sternotomy and a posterior-anterior septal plication using six Teflon felt supported interrupted 1.0 Ticron sutures (SynetureTM, USA) was performed (Figure 1). VSD closure was assessed using transesophageal (Figure 2) and epicardial echocardiography as well and by epicardial auscultation.
Thirty days after myocardial infarction, she underwent an off-pump 'Hamburger' post-infarct VSD repair. The heart was approached through a median sternotomy and a posterior-anterior septal plication was performed using three double-armed Teflon felt supported interrupted 1.0 Ticron sutures (SynetureTM, USA). The Teflon strip was preloaded with sutures and from below the needles were passed through the posterior (inferior) interventricular septum aiming for the anterior part of the septum where the tip of the needle is retrieved. The sutures run just lateral to the LAD to ensure plicating the thicker left ventricular wall rather than the thinner right ventricular wall (Figure 1). The needles were then passed through the second Teflon strip and then tied starting at the apex and working more proximally (Figure 2). VSD closure was assessed using transesophageal (Figure 3) and epicardial echocardiography as well and by epicardial auscultation.

3) Please mention, if in your opinion this technique would be more suited for any particular type of VSD. Would there be any situations where the procedure may not be suitable?

Paragraph four in the discussion has been changed to identify that antero-septal VSD are appropriate for this repair. Posterior or VSDs higher up the septum closer to the AV valve is not appropriate.

Other changes

4) A line added to the last paragraph in the case report section:

'She was found to be asymptomatic and mobilising independently at 6 month follow-up.'

5) Amendment to acknowledgements

Yours sincerely

Thomas Barker