Author's response to reviews

Title: Carney-Complex: Multiple resections of recurrent cardiac myxoma

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Version: 3 Date: 19 January 2011

Author's response to reviews: see over
Dear Professor Zamvar,

Thank you very much for the revision of our manuscript. We enjoyed the remarks of the reviewer, which improves our manuscript, and responded them point-by-point. Changes in the manuscript are marked in red color.

Best regards

Aron-Frederik Popov
Reviewer's report

Title: Carney-Complex: Multiple resections of recurrent cardiac myxoma

Version: 1 Date: 4 January 2011

Reviewer: Philipp Kolat

Reviewer's report:

1. The presented case report concentrates on an infrequent but extraordinary interesting topic. The authors point out in adequate matter epidemiology of Carney complex, their heading to find diagnosis and inpatient postoperative course. I would prefer having more details of intraoperative setting, especially concerning re-do procedures (approach, difficulties to handle with, instantaneous section # tumor-free margin?). Furthermore there´s one more question left: when carrying out resection of right atrium myxoma, why not also having a look at this suspicious left sided structure?

AW:
The reviewer’s concern is correct regarding the left sided structure. When carrying out resection of the right atrium myxoma the left sided structure was defined preoperative as an old surgical suture via transesophageal echo. Moreover, there was no growth process over three years. So this let us assumed that this is not a tumor. Retrospectively, the structure should have been at least inspected.

We inserted in case report section (page 3): “with a tumour-free resection margin”.

In the discussion section (page 5) we mentioned already the surgical risk of redo operations. “Serious surgical problems are especially peri- and epicardiac adhesions from previous operations which increase after every relapse resection. This can lead to a situation where the surgical risk is higher than the risk of death due to complications of the myxoma”.

2. The presented terminology is adequate, nevertheless some few spelling mistakes are still left. In addition, authors’ abbreviations don’t match anymore at the end of this document, comparing them to the beginning.

AW:
A language editing was performed
**Title:** Carney-Complex: Multiple resections of recurrent cardiac myxoma

**Version:** 2 **Date:** 17 January 2011

**Reviewer:** Direndra DR Rajaruthnam

**Reviewer's report:**

Surgical resection for recurrent atrial myxomas is no doubt not an easy task, for the reasons that you have outlined, could you please outline your pre- and intra-operative management in achieving safe sternal re-entry and cardiopulmonary bypass.

**AW:**

The reviewer’s concern is correct. It is well known, that cardiac surgery requiring resternotomy (so-called ‘redo’ surgery) is technically difficult and carries a higher operative risk than a first-time operation. The particular problems are well recognised and include difficulty with access to the heart (due to adhesions, scarring, fibrosis or calcification around the operative site) making dissection and suture placement difficult, prolonged operation times and increased postoperative mortality and morbidity. To avoid complications it is possible to achieve a cardiopulmonary bypass via peripheral cannulation.

Preoperative evaluation for this case was:

1. Computed tomography (CT) scan of the thorax
2. Transthoracic Doppler echocardiogram
3. Doppler examination of the femoral vessels and lower limb arteries.

The preoperative CT-scan of the thorax showed no close adhesions between sternum and the anterior cardiac surface and so we avoid a peripheral cannulation. The operation was carried out by a very experienced surgeon through a resternotomy with an oscillating saw. After intrapericardial dissections a standard cardiopulmonary bypass (CPB) with systemic 32°C mild hypothermia was established via ascending aortic and bicaval cannulation. Cardioplegic arrest was achieved by intermittent antegrade/retrograde infusion of cold blood cardioplegia.

We included in the case report section:

“via re-sternotomy with an oscillating saw after preoperative evaluation (computed tomography (CT) scan of the thorax, transthoracic doppler echocardiogram and doppler examination of the femoral vessels and lower limb arteries).The cardiopulmonary bypass with systemic 32°C mild hypothermia was established via ascending aortic and bicaval cannulation.”

From the last paragraph of the case report, it seems as if the patient was reoperated at a later date after resection of the Right atrial tumour, however, there was evidence of abnormalities on the left atrial side at time of Right atrial exploration. Why was re-exploration of the Left side not considered then?

**AW:**

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There are grammatical errors especially within the case report section that requires revision. In addition minor spelling correction that is necessary.

AW:
Editing and correction was performed