Reviewer’s report

Title: Double chambered right ventricle with severe calcification of tricuspid valve in an elderly woman: a case report

Version: 1 Date: 20 August 2010

Reviewer: Minna Romano

Which of the following best describes what type of case report this is?: An unexpected association between diseases or symptoms

Has the case been reported coherently?: Yes

Is the case report authentic?: Yes

Is the case report ethical?: Yes

Is there any missing information that you think must be added before publication?: Yes

Is this case worth reporting?: Yes

Is the case report persuasive?: No

Does the case report have explanatory value?: Yes

Does the case report have diagnostic value?: Yes

Will the case report make a difference to clinical practice?: Yes

Is the anonymity of the patient protected?: Yes

Comments to authors:

Revision of the manuscript: “Double chambered right ventricle with severe calcification of tricuspid valve in an elderly woman: a case report.”

General comments

This is an interesting case report, with association of two rare disorders: double chambered right ventricle and tricuspid annular calcification. I believe this case is elucidative in clinical practice, but I have some concerns about it’s final publication.

Revisions necessary for publication

The most important lesion in the definition of double chambered right ventricle is
an anomalous muscle band sharing the right ventricle into two cavities. The muscle lesion differs from the right ventricle moderator band. To demonstrate this, the figure 1 must be reviewed. The panel B is consistent with the obstructive flow at right ventricular outflow, but the anatomical lesion must be showed in this same echocardiographic view. If there is not an evident muscle band, a pulmonary subvalvar obstruction might be considered rather than the diagnosis of double chambered right ventricle. Echocardiographic figures must be of better quality. So, it would be better replace panel A (Fig 1) should to a bidimensional image in the same position of panel B (minor axis of left ventricle at aortic level) but without the color flow mapping, pointing out the muscle band.

I can understand the description of a right to left flow through the patent forame oval, however, probably, the tricuspid regurgitation could be a better index of the elevated right ventricular pressure and it could be related to be a clue to seek for a right ventricular obstruction. In figure 4 this image (Patent foramen ovale) is difficult to note and the arrow should be excluded.

The tricuspid calcification needs to be detailed. It seems to be at the annular portion, excluding leaflets. It’s extremely important to correct, many times in the text, that this is a rare lesion when not secondary to rheumatic disease; and this common cause of tricuspid lesions in development countries needs to be excluded in this case. Isolated tricuspid involvement in rheumatic disease is not common, than, it can be done reporting that no other cardiac valve had any alterations in this case. But other causes of tricuspid compromise like carcinoid syndrome or tumors must be considered. It would be better to express tricuspid normal function with a gradient from Doppler flow, since tricuspid area calculations in echocardiography have several limitations.

In Fig 2 the right ventricular obstruction should be pointed and so the annular tricuspid calcification.

Professional English editing of the manuscript is needed. The term “outtract” is systematically present and should be replaced to “right outflow tract obstruction”; replace “bandle” to band, etc.

Some other publications might be relevant to your manuscript and some of them are listed above:

(1)
(2)
(3)

Reference List

3. Romano MM, Furtado RG, Dias CG, Jurca M, Almeida-Filho OC, Maciel BC.

Quality of written English: Needs some language corrections before being published

Declaration of competing interests:

I declare that I have no competing interests