Author’s response to reviews

Title: Hybrid video-assisted thoracoscopic surgical lobectomy of fissureless congenital cystic adenomatoid malformation: a case report

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Version: 5 Date: 28 November 2014

Author’s response to reviews: see over
Reviewer's report-1

Title: Video-assisted thoracoscopic surgical lobectomy of fissureless congenital cystic adenomatoid malformation: a case report

Version: 3 Date: 5 October 2014

Reviewer: Holger Till

Reviewer's report:

This is certainly a nice case report about the benefits of CT-planning before thoracoscopic resection of a CPAM (the new term for CCAM:::).

However as pediatric surgeons we consider a 5.5cm incision almost a "real thoracotomy", even in a 14 year old girl. This large incision allowed for the introduction of several instruments and stay sutures we usually don't see in a "real thoracoscopic resection (with 5mm scope and two 3-5mm working ports!) as seen in the figures.

So I would suggest to put the focus on the radiological work-up, even in the title....

A 5.5cm incision was certainly a large incision. But this operation was Hybrid video-assisted thoracoscopic surgery. Minithoracotomy combined with video assist that was performed predominantly via direct visualization was a secure, integrated, minimally invasive approach to the large fused fissure and the severe adhesion. Hybrid video-assisted thoracoscopic surgery was reported by Morihito Okada. Chest. 2005 Oct;128(4):2696-701.

Hybrid surgical approach of video-assisted minithoracotomy for lung cancer: significance of direct visualization on quality of surgery.

Okada M1, Sakamoto T, Yuki T, Mimura T, Miyoshi K, Tsubota N.

We corrected the operation name from “video-assisted thoracoscopic surgical lobectomy” to “hybrid video-assisted thoracoscopic surgical lobectomy”.

We added this sentence in discussion on page 5:

“We selected hybrid video-assisted thoracoscopic surgery. Minithoracotomy combined with video assist that was performed predominantly via direct visualization was a secure, integrated, minimally invasive approach to the large fused fissure and the severe adhesion.” And Okada’s report was added in reference.

**Reviewer's report-2**

Title: Video-assisted thoracoscopic surgical lobectomy of fissureless congenital cystic adenomatoid malformation: a case report

Version: 3 Date: 12 October 2014

Reviewer: Zacharias Zachariah

Reviewer's report:

This report addresses 2 aspects:

1. In such cases, as the authors correctly suggest, it is absolutely necessary to perform a meticulous preoperative diagnostic procedure in order to know beforehand what the anatomy is.

2. It is feasible to perform this operation video assisted.

For the first aspect it is worth publishing this article that indicates the necessity for good preoperative diagnosis. For the second aspect, in my opinion the authors have to critically report if the method applied is really beneficial for the patient. They performed a nearly 6 cm thoracotomy and used 2 ports in addition and the operation lasted over 5 hrs. In my experience this operation could have been performed with the same results through one thoracotomy of about 10 cm and in half of the time.

This paper could be considered for publication after revision and critical discussion if VATS is the appropriate approach in this case.

This report could be shortened especially the discussion where methods that were not used in this case are discussed.
Thoracotomy would be appropriate for Lobectomy with the large fused fissure and severe adhesion. But 14 years old girl desired a small incision. We selected hybrid video-assisted thoracoscopic surgery. Minithoracotomy combined with video assist that was performed predominantly via direct visualization was a secure, integrated, minimally invasive approach to the large fused fissure and severe adhesion. Hybrid video-assisted thoracoscopic surgery was reported by Morihito Okada. Chest. 2005 Oct;128(4):2696-701.

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The text should be corrected by a native speaker.

EDANZ affiliated with Bio Med Central corrected my manuscript.