Author’s response to reviews

Title: Successful percutaneous coronary intervention for an in-stent chronic total occlusion in a patient with dextrocardia: a case report

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Author’s response to reviews:

Dear reviewers,

thank you for your very helpful comments. Our point-by-point response is attached and the implemented modifications are highlighted in our manuscript.

Reviewer reports:

(Reviewer 1): You started the procedure with a 6 fr right femoral artery sheath. Considering the standard size of the sheath, why didn't you choose a radial artery access? As previously published in this paper: Seven french radial artery access for PCI: a prospective single-center experience, a larger radial artery sheath is feasible and well tolerated by the patients. (please mention this study DOI: 10.1016/j.ijcard.2014.07.134)

Answer: Thank you for this comment. Indeed, we have switched in recent years to the 7-in-6F-slender radial sheath by Terumo, and also routinely perform double arterial access, with one sheath placed in the right radial artery and one sheath placed in the right femoral. In this specific
case, due to known dextrocardia, we chose femoral access because we felt more confident with regards to the very exceptional and rare anatomy. In addition, we have included the mentioned citation in the reworked discussion.

You decide to proceed, first of all, with an antegrade approach. Considering that ISR are often tough lesions, it would be easily to proceed with a retrograde approach. The distal cap of a long lesion is softer than the proximal one. Can you justify your decision? Can you also describe the characteristic of the collateral (septal) channels?

Answer: This was an ad-hoc procedure due to CCS III stable angina. In principle, your comment regarding retrograde approach is correct. However, our in house standard operating procedure recommends antegrade approach first, when collaterals are visible in the angiogram (see also comment to reviewer #2). In this case, collaterals were grade I – II according to Rentrop classification (we added this information to the revised manuscript)

Which would be your second-choice guidewire in case of Hi-Torque failure?

Answer: Next step in the escalation would have been the Ashahi Confianza Pro® or Confianza Pro 12®, then the Ashahi Gaia 3rd ®.

(Reviewer 2): This case is adequately written and described but there are some major issues regarding the CTO technique used to recanalize this vessel. In contemporary CTO procedure it is advisable to use double arterial access, especially if there is collateral flow just from the left coronary, moreover at least a 7fr guiding catheter would have been preferable even for antegrade techniques. This is even more important because of the high JCTO score (even if it could be downgraded to JCTO 2 because of the lack of visual calcifications in the CTO).

Answer: It is correct, that a 7F sheath + guide catheter will allow better backup for performing a CTO-PCI. Since it was an ad-hoc procedure and we needed to employ an unusual guide catheter (Cordis SRC® no-torque) which was not available in 7F, we refrained from changing to 7F material. It is also correct, that a second arterial success to visualize collaterals and to guide the procedure is recommended.
Due to rapid guidewire success and clear demarcation of the CTO segment, we refrained from using a second arterial access to visualize collaterals. We have added this sentence to the revised paper.