Author’s response to reviews

Title: Prenatal diagnosis of a “living” oropharyngeal fetus in fetu: A case report

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Author’s response to reviews:

Dear Pro. Paolo Cavoretto and reviewers:

Thank you for your letter and for the reviewers’ comments concerning our manuscript entitled "Prenatal diagnosis of a “living” oropharyngeal fetus in fetu: A case report" (PRCH-D-19-01237). Those comments are all valuable and very helpful for revising and improving our paper, as well as the important guiding significance to our researches. We have studied comments carefully and have made correction which we hope meet with approval. Revised portion are marked in red in the paper. The main corrections in the paper and the responds to the reviewer’s comments are as flowing:

Responds to the reviewer’s comments:

Ahmed Abbas (Reviewer 1):

1. Very short background about the topic with no information about the condition at all otherwise the paper is good

Respond: As reviewer suggested we added “”in the introduction as for the background about the topic.

Paolo Cavoretto, MD PhD (Reviewer 2):

1. Background. It can be added that in absence of fetal heart beat (as usual occurs) differential diagnosis involves teratomas or other diagnosis?. It can also be added that prognosis is different
in relation to the site of implant of the FIF and subsequent damage to neighbouring organs. Please comment on prenatal diagnosis effectiveness of this condition.

Respond:

2. Case. Line 36. Pulsive is not appropriate, do the authors mean pulsatile?

Respond: As reviewer suggested we modified as “plusatile”.

3. Discussion. The second sentence should be clarified in relation to the comment made at n 1.

Respond: We deleted this sentence.

4. Discussion. reference n 2 is not recent is 18 years old. The authors may cite it in their references since it is relevant paper, just remove the word recent ad add more recent reviews such as the following:


Respond: The original reference 2 is published in 2019. We kept it in the refer list. We added the mentioned reference in the introduction.

5. Discussion. Prognosis of FIF in relation to site of implant (abdominal, thoracic, cranial, etc) needs to be discussed, with reference to cases with postnatal survival. Which are the cases in which postnatal survival could be expected? Certainly survival cannot be anticipated in cases similar to the one in object, however since the disease is very rare it would be helpful to discuss briefly such concept benefit of readers. Please a comment on that.

Respond: As reviewer suggested that we add the progress and the relation to the site as “Lindsey M’s review reported 97% of FIF had a good prognosis after complete surgical resection of the parasitic twin [9]. Few adverse outcomes were reported. One patient with intracranial FIF was alive during follow-up but suffered poor muscle tone and underwent ventriculoperitoneal shunt [10]. One cases with multiple abdominal FIF died on postoperative day 32 due to hydrops [11]. Malignant recur as a yolk sac tumor was reported after retroperitoneal FIF resection [5]. We couldn’t conclude that there was relation between outcome and the site of implant based on the limited cases. However, it is certain that the complication varied among the different locations. For abdominal FIF, abdomen distention, emesis and peritoneal inflammation may be associated. For cranial FIF, obstructive hydrocephalus and mental retardation may be associated. For thoracic FIF, dysphagia and even airway obstruction may occur and therefore emergency surgery
is needed [7-8]. Also, for FIF with multiple or large mass, or with abundant blood supply, heart failure and hydrops is the associated risk.” in the discussion.

6. Conclusion. In the conclusion both of the abstract and of the manuscripts I would add that the rare occurrence of fetal heart activity within the FIF facilitates prenatal diagnosis of FIF, helping in the differentiation with other masses such as teratomas.

Respond: As reviewer suggested we added “Prenatal ultrasound can identify recognizable organ, like fetal heart activity in this case, to make the diagnosis of FIF rather than teratoma. Ultrasound can also provide anatomic details including size, location and surroundings of the mass. Doppler ultrasound can identify the blood supply and assess mass vascularity. These information are important for parent consulting, surgical planning, progress prediction and care management.” in the conclusion and abstract.

7. I believe that this malformation could be detected in the first trimester, please add this concept in the discussion. Are the authors aware of any diagnosi performed before 16 weeks? Please add a comment on that.

Respond: We also believe that this malformation could be detected in the first trimester. However, unfortunately, this woman didn’t perform US in the first trimester because she comes from remote and poor area. She only underwent US in postmenopausal 6-7 weeks to confirm intrauterine pregnancy.

8. Figure 1-2 are adequate. Please the authors add, if possible, coronal and/or midsagittal longitudinal pictures to describe the relationship of the mass with the fetal neck.

Respond: As reviewer suggested we uploaded the coronal view at the oral level in the figure 1.