Author’s response to reviews

Title: Long-term Outcome after Bilateral Lung Transplantation: A Low-Volume Center Experience

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Version: 4 Date: 14 January 2015

Author’s response to reviews: see over
Dear Editor-in-Chief

We would like to thank you and the reviewers for their valuable comments which helped considerably improve the quality of our manuscript entitled “Long-term Outcome after Bilateral Lung Transplantation – A Low-Volume Center Experience” (MS: 5601144161242249). The comments and questions are summarized below, along with our detailed, point-by-point responses to them. Following their suggestions, we have revised our manuscript and Table 2; all the changes were highlighted in red in the revised article.

We were sorry for delayed revising our manuscript and sincerely hope the improved manuscript meets with the reviewers’ and your approval. Thank you for reconsidering our manuscript for publication in the BMC Surgery.

Sincerely,
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Responses to Reviewers’ comments:

Comments or questions from Reviewer #1:

Comment 1:
The authors describe donor lung allocation to be primarily based on the severity of the disease, however neither details about the assessment of severity of disease are stated, nor differences in the indications for lung lung transplantation outlined. Some more details about the allocation algorithm would be interesting to know. Might the overall 1 and 3 year survival rates of only 65% and 56% in Taiwan be related to the allocation algorithm, which takes only severity of disease, but not likelihood of posttransplant survival into account?.

Reply:
When the waiting-lists were listed on the national organ allocation network, they were categorized into three different status according to the disease severity. The status II meant the patient has been qualified as a waiting list and could wait for a suitable donor. The status IB meant the waiting-list needed to be hospitalized due to disease progress. The status IA meant the waiting-list has already relied on ventilator or ECMO support. The first priority of lung donor allocation was the severity of recipient’s disease, which meant that the more severe the underlying disease, the more preference for organ allocation. Because the total national number of LTx in Taiwan was less than 150 cases, the post-LTx survival did not take into account for organ allocation. The other priorities of organ allocation included the results of cross-matching between donor and recipient, and size matching.

We have addressed this point on our revised manuscript from Page 6, line 112 to Page 7 line 122.

Comment 2:
Additionally the results of crossmatching are reported to be important for allocation. Does this imply that only local donors with a chance of prospective crossmatching are used?

Reply:
Because Taiwan is a small island and the national transplant network run well, we have enough time to perform the cross-matching tests and wait for the results before performing LTx. Therefore, the cross-matching results between donors and recipients were all negative in our LTx patients.

We have addressed this point on our revised manuscript from Page 7, line 122 to line 126.

**Comment 3**:

Is identical blood group required or were compatible donors used as well?

**Reply**:

Yes, both identical and compatible donors were used as well.

We have addressed this point on our revised manuscript from Page 10, line 185 to line 186; and we have also revised our Table 2.

**Comment 4**:

In 52% of all transplant procedures unhealthy ares were resected. Was this primarily for size matching reasons or was a localized pathology present in such a high percentage of donor organs?

**Reply**:

Seven of 13 donor surgeries were anatomical lobectomies (three for downsizing resection and four for localized pathological present), and the others were volume-reduction surgeries for size mismatching.

We have addressed this point on our revised manuscript from Page 11, line 195 to line 197.

**Comment 5**:

The limitations of small sample size and retrospective design are adequately addressed. A control group is not an issue in this setting.

**Reply**:

We sincerely thank for the reviewer’s recommendation.
Comments or questions from Reviewer #2:

Reviewer's report:

Although the low volume center, perfect survival for all patients after BLTx at 1-3-, 5- years was 88%, 72%, and 72%, respectively. The authors describe BLTx within 6 years 25 case. The clinical experience was managed well..

Reply:

We sincerely thank for the reviewer’s recommendation.