Author’s response to reviews

Title: Aortoesophageal Fistula and Arch Pseudoaneurysm after Removing of a Swallowed Chicken Bone: A Case Report of One-stage Hybrid Treatment

Authors:

Jia-yu Shen (495645314@qq.com)
Hong-wei Zhang (515651591@qq.com)
Kang-jun Fan (fanmyo@qq.com)
Hu Liao (1044095662@qq.com)
Er-yong Zhang (450763473@qq.com)
Jia Hu (humanjia@msn.com)

Version: 1 Date: 29 Oct 2017

Author’s response to reviews:

Dear Dr. Marco Ettore Allaix

Thank you for your letter dated Oct 11, 2017. We were pleased to know that our manuscript was rated as a case report of importance in its field by reviewers and as potentially acceptable for publication in BMC Surgery, subject to adequate revision and response to the comments raised by the reviewers.
Based on the instructions provided in your letter, we uploaded the file of the revised manuscript on the journal's website.

As you notice, we have revised the manuscript by modifying the Discussion section according to the inquiries and suggestions made by the reviewers. We have uploaded the revised manuscript marked with all changes made during the revision process. The new text is underlined and red colored while the crossed-out text refers to the deleted original text. We guarantee that our revised manuscript conforms to the journal style.

Appended to this letter is our point-by-point response to the questions and comments raised by the two reviewers. As you notice, we agreed with all the comments raised by the reviewers. We would like to take this opportunity to express our sincere thanks to the reviewers who identified areas of our manuscript that needed corrections or modification. We would like also to thank you for allowing us to resubmit a revised copy of the manuscript.

We hope that the revised manuscript is accepted for publication in BMC Surgery.

Sincerely Yours,

Jia Hu

Oct 29, 2017
Reviewer’s report

Title: Aortoesophageal Fistula and Arch Pseudoaneurysm after Removing of a Swallowed Chicken Bone: A Case Report of One-stage Hybrid Treatment

Version: 1 Date: 29 Oct 2017

Reviewer’s report (1):

This is an interesting case report that highlights that TEVAR combined with open repair to address the fistula is suitable option. This has already been reported for or aortobronchial fistula and should be included in the references. Combined endovascular and surgical approach for aortobronchial fistula. Canaud L, D’Annoville T, Ozdemir BA, Marty-Ané C, Alric P.J Thorac Cardiovasc Surg. 2014 Nov;148(5):2108-11.

1) Thank you very much. We have done this in the Discussion section, line 95-96, page 5. Now appeared as:

“Even if associated with favorable perioperative outcomes, TEVAR alone leaves the source of contamination (esophageal or bronchial perforation) untreated and incurs a risk of stent graft infection and/or fistula recurrence[1], which was also reported in the scenario of aortobronchial fistula[2].”


2) Another option that should be discussed is a LSA revascularisation (especially LSA transposition) and zone 2 TEVAR rather than deployment of an occluder.
Thank you very much for your comments. We discussed the revascularization of supra-aortic branches in the discussion section, line 89-93, page 5. Now appeared as:

“An innominate artery-to-left carotid artery-to-left subclavian artery bypass prior to the TEVAR procedure could be an alternative to obtain an adequate proximal landing zone. However, in this case, the instable hemodynamics prevented us from performing these time-consuming procedures. Moreover, the early trans-membrane leakage after stent deployment was another concern, and therefore we chose the occluder to secure a complete exclusion of the aneurysm.”

3) A PET-imaging would also have been useful to clear the risk of stent-graft infection at 6 month.

Thank you very much for your constructive suggestion. A PET-imaging is absolutely an useful technique to clear the risk of stent-graft infection at 6 month. However, our patient never got fever after surgery and the examination results of blood test are normal. Meanwhile, the postoperative thoracic enhanced CT scan showed no mediastinal hematoma and bilateral pleural effusion which could also suggest no infection of the stent-graft. If any signs of infection was observed, we would perform the PET-imaging. This opinion was added to the last sentence in the discussion section, line 111-112, page 6. Now appeared as:

“Adequate antibiotic treatment and lifelong imaging surveillance is mandatory, and a PET-imaging is a useful technique for these patients with any suspected signs of post-surgery infection.”

Reviewers’ reports (2):

At the end of the report the author suggested a summarized approach for management of aortooesophageal fistula. Patients with haemodynamic instability should be treated with endovascular approaches first and then either one stage or subsequent exploratory thoracotomy to plan further treatment. I would suggest depending on the location and extent of aortic involvement, patient should have aortic intervention first preferably with TEVAR, if not than surgery as soon as possible upon making diagnosis rather than waiting for haemodynamic instability. As this conditions can deteriorate rapidly once started bleeding.

Thank you very much for your advice. We have done this in discussion section, line 102-106, page 5-6. Now appeared as:
“Based on our limited experience learned from this unique case, we suggested that management options for AEF patients should depend upon the location and extent of aortic involvement, severity of mediastinal infection and patients’ overall health status. For patients with initial hemodynamic stability, aortic intervention preferably with TEVAR should be done as soon as possible, because this condition can deteriorate rapidly once started bleeding.”