Author's response to reviews

Title: Case Report: Endovascular Treatment of Aortic Pseudo-aneurysm Caused by fishbone

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Author's response to reviews: see over
Reviewer's report:

major compulsory revisions:
1. please rewrite the discussion in a more discursive way and not in the form of a bulleted list.
Response: Thanks for your valuable comment and we have rewritten the discussion as you suggested.

2. What about the treatment of the oesophageal lesion? you mentioned that the APA was caused by aorto-oesophageal fistula, so not only aortic disease.
Response: Sorry for the typo. There was no oesophageal lesion observed in the patient. The diagnosis of lesion was pseudoaneurysms, as the fishbone damaged the aorta. Meanwhile, there was no symptom of gastrointestinal bleeding, occult blood in stool, and abnormal esophageal barium meal examination observed in the patient (Details shown in the following pictures). We have deleted the wrong description of “APA was caused by aorto-oesophageal fistula” in the revised manuscript.

The CT results of patients, preoperation (left) and postoperation (right).
The CT results of patients, preoperation (left) and postoperation (right).

The DR result of patient.
3. how long was the follow-up time?
Response: The follow-up time was 3 years. The latest examination was performed on 11th, August, 2014. The coated stents did not shift, no aortic dissection was observed, the original lesion basically recovered in the CT picture.

4. in your discussion you did not mention one of the most important complications which can occur after this kind of treatment, such as the risk of developing graft infection and a new aorto-oesophageal fistula. What do you think about this? Do you consider the endovascular treatment as the definitive solution or as a bridge solution? Please discuss.
Response: Thanks very much for the valuable comments and we have revised the discussion as you suggested.
Since Dake first reported endovascular treatment for aortic dissecting aneurysm in 1994, Thoracic Endovascular Aortic Repair (TEVAR) has been widely used in clinics and been considered as a definitive solution in aortic dissecting aneurysm treatment. Although TEVAR would cause symptoms, including leakage, stent infection, retrograde aortic dissection and paraplegia, even death, the TEVAR still exhibited obvious advantages comparing to conventional thoracotomy. It is of safety, minimal invasion, quick recovery, few complications, and low mortality, which endowed the TEVAR to be a preferred solution in therapy of thoracic aortic aneurysm and aortic dissection.

5. you mentioned that you chose a 30-200 mm endograft, which implicates the coverage of a long segment of the descending aorta. Did you use any kind of spinal cord protection during the operation?
Response: Postoperative spinal cord ischemia (spinal cord ischemia, SCI) remains a thorny problem. The incidence of SCI was 3~6% after TEVAR [6]. The pressure monitoring and drainage of cerebrospinal fluid (CSF) was important strategies to prevent SCI. However, CSF monitoring would cause central infection, spinal hematoma and lower cranial pressure, so it was still lack of standard criterion and indications in CSF drainage during TEVAR.
In our operation, two strategies were used to prevent SCI, 30-200 endograft and sealing subclavian artery. The 30-200 mm endograft did not cover the T9-L1 section of descending aorta, which was in the opening of root artery. During operation, we did not seal left subclavian artery, which also could reduce the incidence of SCI and paraplegia.

Minor essential revisions
A careful revision of the english language is necessary throughout the text. Minor spelling errors must be corrected: for example pseudoaneurysm instead of pseudoaneurysme, aorta instead of arota (introduction, line 3)
Response: Thanks for your valuable suggestions and we have corrected these typo as mentioned.