Author's response to reviews

Title: Surgical Repair of Inferior Sinus Venosus Defects: a Novel Approach with Unsnared Inferior Vena Cava

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Author's response to reviews: see over
Dear Dr. duccio di carlo:

Thank you for your comments for our article.
Our series of 12 patients from March 2012 to November 2014 is relatively large. That is because the cardiovascular surgery department of West China Hospital is the largest cardiac center in west China. Over 2000 cases of adult cardiac surgery were performed here every year and among them, 90% were valve surgery and adult congenital heart surgery while coronary heart surgery accounts for only less than 10%.

All of these patients were diagnosed preoperatively through transthoracic echocardiography. TTE is our main diagnostic policy while Cardiac MRI were only performed in patients with complex congenital anomaly because MRI is much more expensive. TEE was routinely used intraoperatively but not preoperatively in our hospital.

In this series of patients, except the first patient with accidental diversion of IVC blood to the LA, we had no other surgical complications nor incorrect diagnosis.

If the preoperative diagnosis indicates an inferior SVD, direct cannulation of the IVC may impede surgeons from getting a clear access to the most inferior part of the defect. As we recommended, leaving the IVC unsnared can also facilitate to get a better exposure of the lower part of the SVD and IVC orifice, thus avoiding postoperative IVC - left atrial shunt and other surgical mistakes. And as you suggested, our technique can be useful if the preoperative assesment is incorrect or incomplete as a bail-out manoeuvre.

Thank you for your reminding of the inappropriate using of "imperfection" and we really appreciate that. We have avoid the term "imperfection" to referred to this cardiac anomaly in our article. And the language has been revised by a friend with a good knowledge of English before resubmission.

Best wishes.

Dr. LIN Fushun
Dear Dr. Thierry Carrel:

Thank you for your comments for our article. We found your advises most helpful and have revised the manuscript.

The idea that we want to provide in our article is that for the surgical approach of inferior SVD patients not clearly diagnosed preoperatively, the conventional bicaval cannulation and the tightened IVC tourniquet may lead to shrinkage, folding and poor exposure of the lower part of SVD as well as the IVC opening. In this situation, there is no need to remove the IVC cannulation and recannulate the femoral vein, just leaving the IVC unsnared can also facilitate to get a better exposure of the lower part of the SVD and IVC orifice, thus avoiding postoperative IVC - left atrial shunt and other surgical mistakes. Our technique can be useful if the preoperative assesment is incorrect or incomplete as a bail-out manoeuvre.

As you suggested, our revised manuscripts has been summarized to a short technical detail in about 650 words. We deleted the Introduction & Patients and results passage since they are not essential to the contents of the paper. We hope the revised manuscripts could meet with your approval.

The language has been revised by a friend with a good knowledge of English before resubmission. We are looking forward to receiving your comments and advisement.

Best wishes.

Dr. LIN Fushun