Author's response to reviews

Title: Collaborative Treatment of Huge Intrathoracic Meningoceles Associated with Neurofibromatosis Type 1: a case report

Authors:

Deog Gon Cho (ebstein8@daum.net)
Yong Jin Chang (tsmate@hanmail.net)
Kyu Do Cho (kyudias@catholic.ac.kr)
Jae Taek Hong (jatagi15@paran.com)

Version: 7 Date: 13 August 2015

Author's response to reviews: see over
Dear editor

Revisions made after carefully considering the comments of the reviewers' and editor are as follows.

**For the reviewer 1**

**Introduction:**

1. What is the definition of thoracotomy excision? Total excision or partial incision?
   - Due to the large size of the meningocele, total excision was performed through thoracotomy. Since the wall of meningocele was thick, part of base section was remained to repair defect.

**Case**

1. The quality of figure 2a and 2b was poor.

4. Please use an arrow to illustrate the figure and make readers understand what you meant.

6. Fig 1d was not necessary
   - The figure has changed to the clear one, also arrow has added. Fig 1d is deleted.

2. Why is the initial CP shunt fail to drain the intrathoracic meningocele?
   - According to the neurosurgery (neurosurgeon), CP shunt was ineffective due to the thick meningocele wall.

3. The authors have performed posterolateral thoracotomy through 5th intercostal space.
   - Why do the authors perform definite surgical correction of anatomy?
   - We expected to treat only with CP shunt, however, it failed. Result was not satisfying even after the shunt revision. Thus, surgical correction was decided and thoracotomy was the only
choice since meningocele was extremely large to fill hemithorax.

5. The author used lumbar puncture to lower post-operative cerebrospinal pressure. Please provide the cerebrospinal pressure change and amount. Was the procedure associated with spinal fluid leakage? I could not understand the cause and effect.

: CSF drainage with lumbar puncture was performed to lower post-operative cerebrospinal pressure and to prevent spinal fluid leakage. Although CSF pressure was checked to be normal, there was CSF leakage in patient. Therefore we had kept lumbar drainage system for 5 to 7 days, 5~10cc per hours.

**Discussion**

1. Definite adequate treatment should be surgical correction of anatomy, not excision of meningocele. The authors must indicate the novelty of their case, or the report should be accepted.

: In case of the patient, there was no instability of spine, and since the meningocele was located at anterior portion of the spine, there was no related neurologic deficit. Also, we made a judgement that repairing with meningocele was enough, since it was thick.

**For the reviewer 2**

1. For the postoperative cerebrospinal fluid puncture, it might have been performed by the initiative of a brain surgeon, I hope that it will be described in more detail. How long a period, and how often a frequency did they perform it? When they punctured, did they measure the cerebrospinal fluid pressure? If they measured it, was it high? On what guideline did they determine the amount of drainage?

: Although CSF pressure was checked to be normal, there was CSF leakage in patient. Therefore we had kept lumbar drainage system for 5 to 7 days, 5~10cc per hours.

2. For this surgery, another thing we must pay attention would be the long-term recurrence. It is regrettable that no ingenuity and speculation for preventing the recurrence was seen in this report.

: Postoperatively, because CSF leakage is the most serious potential complication, we performed the reinforcement procedure of the suture site in the cystic wall, and CSF drainage with a lumbar puncture, which is helpful for maintaining constant intraspinal pressure.