Author’s response to reviews

Title: Does Full sternotomy have more significant impact than the cardiopulmonary bypass time in patients of mitral valve Surgery?

Authors:
Zhibing Qiu (qiuzhibing2009@163.com)
Xin Chen (stevecx@njmu.edu.cn)
Yueyue Xu (xuyueyue2015@126.com)
Fuhua Huang (huangfuhua@163.com)
LIqiong Xiao (xiaoliqiong@126.com)
Ting Yang (yangting2005@126.com)
Li Yin (jflsyinli@126.com)

Version: 1 Date: 01 Feb 2018

Author’s response to reviews:

Point-by-point response to reviewer Thank you for consideration of our manuscript for publication in your journal. We have reviewed the above manuscript according to your reviewer’s comments. Reviewer # 2 Dr. MARCO ANTONIO PRACA OLIVEIRA 1) You say that MIMVS is the standard approach for your group, but since 2011 only 25% of the cases were done by this approach. Dr Marco, thank you very much for your kind comments, and those are very important issues that you pointed out. Because we have several surgeons but most of them can only use the standard approach, therefore only 25% of our cases are done with this MIMVS approach. 2) In the surgery technique, which cannula you use in the ascending aorta? Maybe you could describe better this cannulation or add a picture of the cannula in place. Regarding cannulation, it is now decribed on page 3: This consisted of retrograde arterial femoral perfusion, long cannula femoral venous drainage, and antegrade cold crystalloid blood cardioplegia via the ascending aorta by a needle vent catheter. The aorta was crossclamped using the flexible Chitwood aortic clamp (Cardiomedical GmbH, Langenhagen, Germany) directly through the thoracotomy incision. If direct aortic cannulation is utilized we typically use a standard #20 straight aortic cannula (Edwards Life-sciences, Irvine) or Easy Flow TME stech aortic cannula (Estech, San Ramon, CA) which can facilitate direct cannulation of ‘distant’ aortas. But we would never advocate cannulation of an aorta where the surgeon could not apply direct and immediate finger pressure for control of potential bleeding. 3) How was the incidence of rheumatic and degenerative valve disease? How many did you repair? Among 283 MIMVS patients, 57.2% had rheumatic valvular disease; 42.8% had degenerative valve disease. There were 196 mitral valve replacements (69.3%) and 87 mitral valve repairs (30.7%) in the cohort. We added some information in Table 1
and 2.4) In the follow-up, you describe only one re-operation, but on table four you showed three deaths in each of the groups. Thank you, sir. This is a mistake. We have revised it in Table 4, and we have changed the sentence in the text on page 5.5) There are several mistakes in your tables, especially on the "p" values that you should address. The reviewer is correct and we have revised the mistakes along with the ‘p’ values in Table 4.