Author’s response to reviews

Title: Hybrid Bronchoscopic and Surgical Resection of Endotracheal Angiomatoid Fibrous Histiocytoma

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Author’s response to reviews:

Point-by-point response

Reviewer #1: Indeed an interesting and rare case report.

Response to Reviewer #1: Thank you for your review. We incorporated most of your comments in the revised paper and as a result it has significantly improved the quality of our paper.

Major revisions:

One very important point is missing:

1. What was the exact location of the tumor - e.g. distal end of the tumor how many centimeters from the carina?

From what we can see from the CT-scan the tumor is located right where the manubrium starts - right at the jugulum - so with reclination of the head this location is well accessible using a cervical approach (and only hardly accessible from a thoracotomy).
This also means that the tumor was not located in the 'distal trachea', rather one should say 'at the transition from the cervical to the thoracic part of the trachea'. or 'in the middle part of the trachea'.

Again, based on this 'assumption' of the tumors location (no offense, but this is what the reader can see from the CT-scans), most surgeons would choose a cervical approach for resection...

Based on the abovementioned discussion the case presentation should be adapted accordingly:

The term 'distal tracheal resection' seems not appropriate, nor should the described cervical approach be compared with a thoracotomy. Rather emphasis can be made on the fact that the authors did not need to do a manubriotomy for the exposure/resection of the lesion.

Response: The exact location of the tumor was 4 tracheal rings (approximately 2 centimeters) above the carina (as can be seen in Figure 1D (and 1A)). We have added this information to the revised manuscript.

The total length of the trachea is 10 cm and we can therefore conclude that the tumor was located in the distal third of the trachea. This can also be appreciated on the chest X-ray (Figure 1 A) and on the bronchoscopy image (Figure 1D). The 2D CT-scan image is a reflection of 3D anatomy. In reality (3D) the trachea runs posteriorly and caudally (with a 45° angle) and therefore it may seem like the tumor lies at the level of the manubrium on a 2D CT-scan image, but in reality (3D) it is located deeper in the trachea (which can be clearly appreciated in Figure 1D). We therefore think that the main message of this paper and the comparison of a cervical approach with a thoracotomy still stands. We do however appreciate your detailed explanation and comment.

Minor points:

1. How was the anastomosis made - which thread (Vicryl, PDS..)? - interrupted and/or running sutures?

Response: The anastomosis was made with interrupted 4-0 PDS sutures (and two lateral interrupted 2-0 Vicryl sutures for approximation and anastomotic tension release) We added this to the revised manuscript.
2. There is no ruler next to the specimen (Figure 1 F) which makes it hard for the reader to estimate the size of tumor and specimen, nevertheless you describe the tumor size being 15mm in the text. If you have a pic of the specimen with ruler, then please use that one (if same quality).

Response: Unfortunately we do not have a picture with a ruler of this specimen. We agree that that would have been better. However, we do clearly describe the size of the tumor (as you mentioned) in the text.

In summary an interesting and rare case, well written (apart from the abovementioned issues) and therefore clearly suitable for publication once the relevant revisions have been made.

Response: Thanks again you for your review. We incorporated most of the comments in the revised paper and as a result it has significantly improved the quality of our paper.

Reviewer #2: This report showed an endtracheal AFH tumor. A figure was composed of 8 photos, however, histopathological figures are very important in this report. They should separate those from figure1.

Response: Thank you for your positive response. We separated the histopathological figures from figure 1 and assembled them into a new figure 2. We changed this in the revised manuscript and we think it has significantly improved the quality of our paper.

All our changes are highlighted in yellow in the revised manuscript!