Author’s response to reviews

Title: Intrapericardial gossypiboma found 14 years after coronary artery bypass grafting

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Letter answering reviewers’ comments

The first reviewer’s comment: I would like to thank the authors for presenting this interesting case. In my opinion there is scope to publish this article. However the focus of this article should be placed on how this error occurred and how this will be prevented in the future.

1. The quality of syntax and wording needs significant improvement. There are wording and grammatical errors throughout the manuscript. In my opinion this article should NOT be accepted for publication until significant improvement is achieved in the language of the article. I would suggest that the author have this article proof read by a native English language speaker prior to re-submitting.

2. In the background section 1000-1500 operation --> per year? in the world? give more specific quantification please

3. Please change the term "Gauze" for "Surgical Swap" and also provide detail on the size of the swab

4. Most importantly the authors need to give significantly more detail as of how this event changed their institutional practice of counts? Do they use WHO checklist and do they do instrument counts before chest closure routinely?
5. This event had a significant impact on the health of this patient. Was this incident discussed at the morbidity and mortality meeting in your institution? Did the authors approach the original team who did the cardiac surgery and inform them of this error? How did this event changed their practice. This needs to be detailed in the manuscript. Few such cases have been reported in the literature. Hence per se this not an original report. However many manuscripts have not detailed how this incident made their practice of surgery safer so that such incidents "never events" never happen again. As such this manuscript will require substantial revision.

Answer: We thank you very much for your comments and for pointing out the need to emphasise our measures for preventing such errors to occur in the future and to revise the language structure. We made several corrections according to your suggestions.

1. We performed a double check of our manuscript by two native English speaking doctors, Dr. Dritana Marko at the University of Texas Health Science Center at Houston (that we added in the section of acknowledgements of her help) and Dr. Lindita Coku at the Department of Cardio-Thoracic Surgery of Mount Sinai Hospital in New York to review English and medical terminology.

2. Sorry there was an error. We wanted to say that the incidence is 1/1000–1500 abdominal operations.

3. We changed the term "Gauze" for "Surgical Swap" but it was impossible to assess the size of swab because it was totally degraded. However we have mentioned the diameter of the lesion when we have described the CT-scan.

4. Although this error didn’t happen to us, since this case, we have been more cautious in our surgical practice, counting everything at the beginning of the surgery and before chest closure as described by WHO checklist. We don’t close the thorax if something is missing and some time we have used the C-arm to control. We are currently using only surgical swap with radio opaque marker inside. (We added this paragraph in the section of discussion.)

5. As we have described in the manuscript the patent had a significant health impact after the surgery leaving the hospital symptom free. We have discussed this case even in our ethics council but we didn’t contact the original team that did the cardiac surgery because it happened many years ago in a clinic out of our country and the patient didn’t give us exact information.

The second reviewer’s comment: Very interesting case report. I was surprised that there are so many cases published with forgotten gauzes. Well done ! I think that the spelling of the word gauze is with z and the last sentence (Such thing has to become each of us more cautious in our everyday work. ) doesn't sound quite right. I am sure you will take care of these. Apart of the above comments I do have the following optional recommendations: - immediate post-op chest x rays after the first CABG operation 14 years ago would be useful to have for training purposes. (if applicable) -Pre-op chest x ray before the recent re-exploration would be useful as well for the
same reasons. -Myself personally I would add a comment for the reasons why you choose the thoracotomy approach. Maybe is obvious but it wouldn't harm to mention even profound reasons.

Answer: We are very grateful to your comments on the manuscript. We have corrected the manuscript regarding language and grammar. The last sentence changed in (This case aims to raise awareness among surgeons and nurses in the operating room and doctors in their everyday work to prevent such errors and future complications that may deteriorate patients' health).

1. It wasn’t possible to have immediate post-op chest x rays after the first CABG operation because it happened many years ago in a clinic out of our country and the patient didn’t give us exact information.

2. About the pre-op chest X-ray it was our choice to not publish because it wasn’t digital and of a very low quality.

3. We made several corrections according to your suggestion trying to make clearer the reasons of thoracotomy. In our case, the radiologic image was initially showing a big mass of mediastinum that involved the pericardium and was accompanied by shortness of breath and dry cough. The history of past surgery in this patient additionally suggested that an intrapericardial foreign body could be producing the current symptoms. We decided to perform the exploratory surgery as the best diagnostic and treatment option because it appeared very well circumscribed. (We added this paragraph in the section of discussion.)

The third reviewer’s comment: Dear authors Thank you for submitting this "case report" to the Journal of Cardiothoracic Surgery. I was pleased to receive it as a reviewer. This is very important issue, albeit rare. In my career I have seen one almost same case but accidentaly found during re-do CABG. I can say everything you wrote is true and we all have to be aware of that possibility. However, case reports are supposed to show something that is so rare and probably not seen before. You are to be congratulated for this case and for awareness of the prevention measures that are required in order to avoid this. However, this manuscript does not add to the current knowledge, rather shows us how something apparent may be oversee over so long period of time. I see this as a possible book chapter in some surgical book, but somewhat this, at least in my opinion, is not what is expected to be presented in "case reports".

Answer: We are very grateful to your comments on the manuscript. We respect your decision but we wanted to emphasize with this article not only the error that can happen to everybody in a stressful surgery but also the long period of time that this error persisted from one doctor to the other for 14 years. The patient had performed yearly chest X-ray and cardiac ultrasound and nobody had told him about this problem. So this article is raising two distinct problems:

1. It is necessary to perform the WHO checklist in the operation theater counting surgical swamps and surgical instruments routinely at the beginning of surgery and before the wound closure. The surgical swamp has to be with radio opaque marker inside it.
2. Another problem is the incorrect follow-up of the patients after the surgery that in my opinion it was the worst error.