Author’s response to reviews

Title: Large left atrial cavernous hemangioma, A case report

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Author’s response to reviews:

Dear editor:

Thank you very much for your decision letter and advice on our manuscript entitled “A large left atrial cavernous hemangioma”. We also thank the reviewers for the comments and suggestions. Accordingly, we have revised the manuscript. All amendments are highlighted in red in the revised manuscript. In addition, point-by-point responses to the helpful and valuable comments are listed below this letter.

We hope that the revision is acceptable for the publication in your journal.

Look forward to hearing from you soon.

With best wishes,

Yours sincerely,

Rihao Xu
Replies to Reviewer 1

1. This manuscript needs intense English language spell check.
Response: Correction has been made in the revised manuscript.

2. Please describe the symptoms of the patient that he presented in.
Response: I'm sorry we didn't make it clear in this article. We are also interested in the clinical symptoms of the disease. However, after repeated questioning of the medical history, we confirm that the patient had no clinical symptoms. Modifications have been made as appropriate(page 3 line 11-12).

3. In your discussion and reviewing the previously reported cases, please describe and elaborate more about these in terms of diagnosis, management, outcomes.
Response: Thank you very much for your insightful suggestion. We have added in the discussion section(page 4 line 11-23, page 5, line 1-16).

4. Please provide any comment about the follow up status of this patient.
Response: We have added the follow up status of this patient(page 4 line 8-10).

5. Describe how did you manage the wall of the left atrium, did you use a patch or just you close primarily.
Response: I'm sorry we didn't make it clear, we didn’t injure the wall of the left atrium. We opened the left atrium to confirm the invasion status of the left atrial wall. The incision was closed primarily with 4-0 Prolene suture. some details have been added (page 3 line 23, page 4 line 1).

Replies to Reviewer 2

Reviewer #2: I would like to thank the authors for presenting this case report titled "A large left atrial cavernous hemangioma".

It is a successfully managed rare case. I have some few comments:

1. Page 3 line 12 " Histologically, cardiac hemangiomas can be classified under three categories: capillary, cavernous, and arteriovenous. the authors did not mention a reference for this classification.
Response: This reference has been quoted as Ref.2 in the revised manuscript.

2. Page 3 line 24; the patient is 56 years female a coronary angiography should be done before surgery to exclude coronary artery disease in this age.
Response: Thank you very much for your insightful suggestion, we have added the discussion in our case report. We did not perform coronary artery angiography, because the patient had no significant medical history of coronary artery disease (CAD) and computed tomography angiography has a high evaluability and diagnostic accuracy in detecting significant coronary artery disease (CAD). (page 5 line 1-4)

2. some phrases that is not fully understood because of their language construction for instance: In this case we successful conduct the surgery (page 3 line 13), left atrial (page 3 line 12, 26, 29....), And while computed tomography (page 3 line 29), and also nor obvious damage in the coronary artery or obvious abnormality in the heartbeat, (page 3 line 41,42).

Response: Correction has been made in the revised manuscript.

3. Page 4, line 18,19; the patient was observed to have a short ST-segment elevation, though coronary artery bypass (CABG) grafting was not performed during the operation. is there any investigations done to exclude acute myocardial infarction? especially no reported coronary angio done before surgery.

Response: Thanks for your positive comment on the present study and insightful suggestion on further investigation. The change of ST-segment was considered a transient coronary artery spasm induced myocardial ischemia. We did not perform coronary artery bypass grafting because no stenosis was detected preoperatively by coronary CTA. Post-operative Electrocardiograph showed no myocardial ischemia or infarction. Post-operative hypersensitive serum troponin did not support the diagnosis of myocardial infarction. After careful consideration, it was removed in our revised manuscript.