Author’s response to reviews

Title: One-lung ventilation to treat hepatic dome lesion: a further step towards minimally invasive surgery

Authors:

Francesco D'Amico (drdamico@hotmail.com)

Simone Serafini (seraf87@gmail.com)

Michele Finotti (michele.finotti@studenti.unipd.it)

Marianna Di Bello (m.dibello@rocketmail.com)

Chiara Di Renzo (chiara.di-renzo@hotmail.com)

Umberto Cillo (cillo@unipd.it)

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One lung ventilation to treat hepatic dome lesion ecc. F.D’Amico et all

Response point by point requested

ASSOCIATE EDITOR

the title is a bit catchy to make the article more interesting infact is : “ a further step towards minimally invasivity “

the diaphragm damage can also occur open, but if you collapse the lung and block the diaphragm excursion you reduce the risk considerably and i salso reported in the conclusion  line 24-30

REVIEWER 1

Point 9-1

Done, changed in the text as suggested
Point 9-2

As previously described in the response to the editor (the title is a bit catchy to make the article more interesting in fact is: “a further step towards minimally invasivity”), furthermore, it should be considered that laparoscopic or thoracoscopic ablation (already considered minimally invasive surgery) is certainly more invasive than percutaneous surgery.

Point 9-3

As described in the conclusion line 14-22, the risk of morbidity still high in the CT guided ablation and also with the use of artificial ascites. The difference in this case report is that the diaphragm is blocked because the lung is not ventilated. So is more easy to modulate the ablation during the real time US. (described in the conclusion line 24-29)

Point 9-4

Erased the sentence as suggested

REVIEWER 2

Thanks to have underline the useful contribution of the paper in the point 8 corroborating my response of clarification previously made

REVIEWER 3

POINT 9-1

Thanks to have appreciate the title as impactful to the readers that was my purpose

POINT 9-2

The diaphragm is always in motion even with the CT guided. But if I have the possibility to have a continuous vision with US and the diaphragm stopped, the result is better. (discussed in the conclusion line 24-29)
POIN9-4

As shown in figure 2, the diaphragm is beyond the lesion and MW access is distant from the site of the previous operation.

POINT 9-5

Modified figure 1 with the arrow as suggested, in figure 2 the area is well described by the T (tumor) and the needle route. Not available CT sagital reconstruction.

POINT 9-6

As shown in Figure 2, the area of ablation is at the end of the ultrasound window, in fact we see the diaphragm, the vena cava and the right atrium.

All this was possible due to the immobility of the diaphragm and of the patient which allowed to correct the trajectory of the needle during the entrance. Described in the conclusions.

POINT9-7

As you can see in the CT A-B of figure 1 there is no evidence of captance of contrast in another nodule.

POINT9-8

No others references found.

POINT 9-9

Add radiologists in the acknowledgment as suggested.

Acknowledgments: We thank the Director of Radiology of the Veneto Oncological Institute, Camillo Aliberti, and his staff, and the Director of the Radiology of Padua University, Diego Miotto and his staff, for their review of the images.

POINT 9-10

Modified figure 1 with an arrow as suggested.
POINT 9-11

I confirm that D is diaphragm

Thank you for the time dedicated to my case report

Francesco D’Amico