Author’s response to reviews

Title: Transcatheter Occlusion of Giant Congenital Coronary Cameral Fistulae: Case reports

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Reviewer #2 comments:

9. Additional comments for the author(s)?

The authors report three cases of coronary-cameral fistula which have been successfully managed using transcatheter coil closure. In case 1, what was the indication for surgical ligation at the first place?

Response: Page #4 of the manuscript: After discussion with the surgical team, it was concluded that the fistula would be too big for successful deployment of a device without the risk of embolization. Surgical ligation of the fistula was then elected and performed.

Why did the surgical ligation fail?

Response: The surgical ligation was performed successfully but there was a residual fistula that required closure. Further responses on page #4 and 8 of the manuscript. The response on page 88 reads "A residual fistula was documented in our 10-years-old patient who had to undergo percutaneous transcatheter closure. Surgical ligation involves placing an external suture around the fistula. Should the surgical knot not be tight enough, the lumen may not be completely occluded resulting in a residual fistula. Unlike percutaneous closure, where angiography is used to cross check and confirm successful occlusion, there is no similar intraoperative tool for the surgeons, sometimes resulting in residual fistulous flow".
In the discussion part, the authors mention several disadvantages of surgical over percutaneous transcatheter closure like sternotomy wound and associated healing complications, wound infection, post pericardiotomy syndrome, bleeding, cardiopulmonary bypass and hospital stay. How significant are these differences? Are there any studies in literature comparing the two procedures and complication rates with respect to coronary-cameral fistula.

Response: Page #9 of the main manuscript. There are no randomized clinical trials that have compared treatment outcomes and complications of transcatheter closure versus surgical ligation of CCF because this is a rare condition to get adequate numbers for an appropriate randomized clinical trial. Armsby et al compared his cohort of 33 patients who had successful transcatheter occlusion of CCF with published surgical reports and found no differences in outcomes and complications between the two techniques. However they did not discuss the social impact of a permanent surgical sternotomy scar and length of hospital stay which are obvious differences between surgical ligation and transcatheter closure of CCF.

We have revised the grammar and the changes are highlighted on the revised manuscript.

We think publication of the successive closure of these rare cases of congenital coronary cameral fistulae from our hospital is an important contribution to the global academic literature on management of coronary cameral fistulae.

Reviewers #1 and #3 did not have comments that needed us to address.