

Table 1. Response to reviewers' comments: Manuscript NO: 25365/World Heart Journal

Reviewers' comments	Author's response	Tracked
<p>Code: 00506608</p> <p>This is an interesting and very unusual case. It appears that the patient was managed with a stent in a stenotic vessel which might help address her arrhythmia.</p> <ol style="list-style-type: none"> 1. However, it is unclear how and why the authors chose the management plan that they did - the sequestration is still there and at risk for problems? 2. Given her presentation - was there consideration to lobectomy (as is often the management for sequestration) and/or ligation of the anomalous artery off of the RCA? 3. It appears the artery is still patent - should this be ligated? 4. Was there consideration given to coil embolization at the time of her PCI/cath? 5. The discussion regarding some of the management nuances should be expanded on - particularly the indications and options for the different interventions. 	<p>The chief complaint in this patient was angina and ischemic ventricular tachycardia due to coronary disease and coronary steal. At the time of presentation our patient was not willing to lung resection. Therefore, we proceeded with angioplasty of coronary. We planned elective resection of sequestration and ligation of systemic arterial source at same time. In asymptomatic patients, surgical resection or coil embolization is controversial [1]. Elective surgery is preserved for the complication like lung infection but the exact timing of such intervention is not known [2]. However, one recent observation suggests surgical resection is safe in asymptomatic patients [3]. Therefore, we decided to follow carefully for pulmonary symptoms and elective surgical resection at the earliest symptom of lung infection or haemoptysis.</p> <p>We do agree it is patent even after jailing by stent. However, it can be ligated during elective resection of resection.</p> <p>Our current management was focused on the angioplasty of the critical stenosis in the right coronary artery which has three implications :1. Improve the ischemia in the area subtended by dominant RCA territory ,2. Reduce the coronary steal to the minimum because the stenosis was just distal to the anomalous branch supplying ILS and 3. The jailed anomalous artery to ILS may be closed during follow up.</p>	<p>Mentioned in the discussion paragraph with references mentioned</p> <p>Discussion</p> <p>In the discussion paragraph ,the various treatment optioned have been included</p>
<p>Code: 00060498</p> <p>Manuscript is well written.</p> <ol style="list-style-type: none"> 1. Authors may highlight the learning points more clearly 	<p>The incidence of intralobar sequestration(ILS) of right lower lobe(RLL) is 20% of pulmonary sequestration(PS). It is rare to encounter ILS of RLL is supplied by right coronary artery(RCA). The anomalous artery to ILS induces ischemia in the territory subtended by RCA.A significant stenosis of RCA just distal to the anomalous artery supplying ILS is extremely rare which further worsens coronary steal causing rest angina and ischemic ventricular tachycardia. Angioplasty of right coronary stenosis not only relieves ischemia in RCA territory but also jails the anomalous artery to ILS.</p>	<p>In the revised submission ,we have addressed these issues in the abstract and core tip along with case report section.</p>

<p>Code: 00211914</p>	<p>This manuscript (MS) described a rare and interesting case of “intralobar pulmonary sequestration” which was supplied by two vessels: the right pulmonary artery and the right coronary artery. The clinical presentations of dual blood supplies and repeated episodes of ventricular tachycardia (VT) were very unusual. Although it is an interesting case, the following areas will need to be revised before consideration for acceptance.</p> <ol style="list-style-type: none"> 1. Major comments: 1. Page 2, Case Report Section, Line 1-3. Authors stated that “she had undergone recently radiofrequency ablation (RFA) for ventricular tachycardia (VT). Coronary angiogram prior to RFA had mild RCA disease.” It indicated that she did not have significant coronary artery stenosis at the time she underwent radiofrequency ablation treatment for VT. Thus, the VT was an association but not necessarily resulted from significant coronary artery disease (CAD). Therefore, it is not appropriate to use the term “A cause of ischemic VT”. The title of this MS should be revised. Authors may consider revising the title to: “A rare presentation of intralobar pulmonary sequestration associated with repeated episodes of ventricular tachycardia”. 2. This MS provided two figures and a video that were related to coronary artery angiograms. However, an image supporting the diagnosis of intralobar pulmonary sequestration is lacking. Suggest adding an image such as computed tomographic (CT) scan or magnetic resonance imaging (MRI) which would confirm the presence of intralobar pulmonary sequestration 3. Minor comments: 1. 	<p>Thank you for nice suggestion The title is changed</p> <p>This is well known case intralobar pulmonary sequestration (ILS) from last 3 years before presenting to us. So, we didn't feel the necessity of CECT of chest again. Asymptomatic presentation, nonhomogeneous opacities in right lower lobe in chest X-ray and selective right coronary angiogram showing a branch of RCA supplying right lower lobe support the diagnosis in the context of previous CECT documentation in 2014. We accept this as limitation because the quality image available with the patient was not good.</p>	
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3. Wang LM, Cao JL, Hu J. Video-assisted thoracic surgery for pulmonary sequestration: a safe alternative procedure. *Journal of Thoracic Disease*. 2016 Jan 21;3(2).