Dear Reviewers,

We would like to thank you for such an extensive review of our manuscript. We have attempted to clarify all the concerns and revised the manuscript based on your comments. Please refer below for specific response to each comment. Hope you will consider it favorably.

In this case, I think that the distance between the box and the Defib Coil is also important to consider. In figure 1 they seem too close.

We addressed this point in the following sentence: “Additionally, it reduced the distance between the can and the coil, effectively creating a smaller bipolar current and sparing the left ventricle from the current needed for defibrillation”

The importance of the RV lead site should be discussed: is there any data of trials favoring an ideal location? Which location and which trials?

 We addressed these points with the addition of the following sentences:

It is suggested that the RV lead be positioned to the true ventricular apex1. More proximal positioning of the lead results in higher DFTs, but if the RV lead is positioned closer to the interventricular septum or RV outflow tract, DFTs are improved (2). A recent study reported similar rates of high DFTs in patients with RV apical leads (3/108) vs RV septal leads (3/107) [SEPTAL study – Mabo et al; JCEP August 2012]. The SPICE trial is currently underway and should help to answer the question of optimal RV lead position. It is important to consider that as ICD systems adopt the dual coil single lead configuration it will become more difficult to manipulate positioning to optimize DFTs.

The possibility of changing the vector in a treatment (1st and 2nd shock with one vector and the 3rd with another, or something in this direction) window should also be commented

 We added a discussion about this: Some ICD brands allow reprogramming of the shock configuration even within a single treatment window, which theoretically increases the chance of successful defibrillation. Data suggests that a configuration where the RV lead is the anode results in the highest success of defibrillation, but a small population of patients benefits from the reverse configuration (2).

The authors should also comment on the increasing use of single coil leads and problems that may arise from this practice concerning this subject.

 We added a discussion about this: It is important to consider that as ICD systems adopt the dual coil single lead configuration it will become more difficult to manipulate positioning to optimize DFTs.

Fixation of ICD generator to the pocket in order to avoid changes in Def vectors should be mentioned.

 We added a brief comment about this: This case underscores the importance of securing the generator in place, as this patient would have been spared multiple shocks and an invasive medical procedure had his generator been better secured.

In light of the recent MADIT-RIT trial it would also important for the authors to consider the hypothesis of changing the programation of the device in order to decrease the high number of therapies since it is now known to be deleterious.

 The authors agree with this hypothesis, but feel that a discussion of reducing inappropriate therapies is beyond the scope of this paper.

If is also important to discuss the new option for patients that are not under pacing, the subcutaneous ICD, since the results of the MADIT-RIT also seems to theoretically favor this therapy. However, the authors should also discuss what can be done with these new devices to overcome similar problems if they occur."
 We added a brief discussion of the EFFORTLESS study: Even the newer, entirely subcutaneous ICD systems are reliant on proper positioning. In a recent article describing the initial Dutch experience with the device, three patients received inappropriate shocks due to lead migration. This complication was solved by adding an additional suture sleeve