

Nice work - well designed on an interesting hypothesis that potentially can change the TAVI clinical practice. The paper is very well written.

We thank the Reviewer for this comment and for highlighting the future potential of our study.

The data reflect a single center and are non-randomized, which is adequately emphasized (please also in the abstract)

We have now added this to the abstract as follows:

“This was a retrospective non-randomised single-centre analysis of consecutive patients undergoing TAVI.”

Minor comments: - A 19 months' fu are not especially long term (consider rephrasing)

We thank the Reviewer for this comment. We have now highlighted this in the main findings of the study as follows:

“The main finding of this study was that our devised approach of selective CA tailored to patient clinical characteristics was safe and feasible over a relatively short follow up.”

Additionally, we have amended “long term” to “post procedural” in the limitation section:

“We had to exclude almost 25% of patients who underwent TAVI in our centre as their post procedural follow up could not be ascertained.”

Extensive calcifications on CT and Impaired LV function - please provide a numerical cutoff point to aid future clinical practice/ research

We thank the Reviewer for highlighting this point. We have now added the following to the Methods:

“Impaired left ventricle systolic function (ejection fraction \leq 50%), particularly if there were regional wall motion abnormalities; or

Extensive calcifications (>70% of lumen diameter stenosis) involving the proximal segments of left or right coronary arteries detected on CT as part of TAVI work up”

No data provided regarding CA complications - these would probably add to your hypothesis to avoid pre-TAVI CA

We thank the Reviewer for this suggestion. There were no reported complications associated with angiogram in any of the cases. We have now added this to the manuscript.

Supplementary comments: This is an unsolicited manuscript. No financial support was obtained for the study. The topic has not previously been published in the WJC.

We thank the Science Editor for this comment, but we have to highlight that this was an invited manuscript.

Issues raised: (1) The “Author Contributions” section is missing. Please provide the author contributions;

We thank The Science Editor for this comment. We have now added authors contributions accordingly:

“Conceptualization: MA. Investigation: AM, RD, RE, AZ, MA. Methodology and project administration BB, DM, MA. Data Curation and software MA Formal analysis: MA.

Resources: BB, DM, AM, RD, RE, AZ, MA. Writing original draft and preparation BB, MA Writing review and editing all authors.”

(2) The authors did not provide original pictures. Please provide the original figure documents. Please prepare and arrange the figures using PowerPoint to ensure that all graphs or arrows or text portions can be reprocessed by the editor

We thank the Science Editor for this comment. We have now provided the tiff images separately.

(3) PMID and DOI numbers are missing in the reference list. Please provide the PubMed numbers and DOI citation numbers to the reference list and list all authors of the references. Please revise throughout

We thank the Science Editor for this comment. We have now added DOI alongside all authors list.

The “Article Highlights” section is missing. Please add the “Article Highlights” section at the end of the main text.

We thank the Science Editor for this comment. We have now added Article Highlights as below:

“Background: Routine coronary revascularisation pre-TAVI was not associated with improved outcomes, yet, coronary angiogram (CA) is still performed as part of TAVI work up.

Motivation: The lack of data showing consistent benefits in pre-TAVI revascularisation challenges the need for routine invasive coronary angiogram before TAVI procedure

Objectives: To assess whether a selective approach to perform pre-TAVI CA is safe and feasible

Methods: Retrospective analysis of consecutive patients undergoing TAVI who underwent CA versus those who did not was performed. Decision to undergo CA pre-TAVI was tailored to patients’ clinical characteristics

Results: The primary endpoint was a composite of all-cause mortality, myocardial infraction, repeat CA, and re-admission with heart failure was comparable between the two groups.

Conclusions: Selective CA is a feasible and safe approach. The clinical value of routine CA should be challenged in future randomised trials

Perspectives: Future randomised clinical trials are required to test whether selective CA is a safe approach.”

