

Dear Editorial Office:

According to the review comments of this article, I have made the following modifications, and I have marked the revision with a highlighter in the text.

Reviewer 1:

First of all, I would like to thank you for your valuable comments! These suggestions play a very valuable role in improving the quality of this paper!

1. We try our best to provide unified technical training, provide consistent examination conditions. In addition , we strictly control objective indicators, make diagnosis according to diagnostic criteria and minimize bias with skilled sonographers.
2. Because we have done a good job of uniform technical training, and the sonographers have more than 5 years of work experience, so the reproducibility results for echocardiographic findings are very well.
3. In figure 3, there are both annulo-leaflet mitral ring and parachute mitral valve .

Reviewer 2:

Thank you very much for your suggestions! This is the key questions that should be presented to the readers. I have made corresponding supplements in the article, and the details are as follows:

1. Shone's syndrome which includes Annulo-Leaflet mitral ring (ALMR), parachute mitral valve (PMV), subaortic stenosis (subAS), and CoA. The corresponding pathological changes are as follows: ALMR is the septum of the region above the annulus of the mitral valve; PMV is the congenital mitral stenosis, the main pathological change is papillary muscle fusion resulting in mitral chordae tendineae attached to a single dominant papillary muscle, resulting in the mitral valve can not fully open during ventricular diastolic; subAS has two common types: ①Limited subaortic stenosis includes septum inferior aortic stenosis, which is caused by 1.0 ~ 1.5cm fibrous septum below the aortic valve, and fibromuscular septum inferior stenosis. ②Diffuse subaortic stenosis is a tubular stenosis caused by diffuse thickening of the outflow tract muscle of the left ventricle; Coarctation of the aorta is a local or diffuse narrowing of the aorta, resulting in reduced blood flow.

2. All patients had no cyanosis, and only one patient had symptoms of dyspnea and left heart failure (1/66, 1.5%) .

3. Subaortic stenosis was misdiagnosed as aortic stenosis in 1 case. Because the subaortic septum is often very close to the aortic valve, it is easy to be mistaken for aortic stenosis, but in fact, it is the subaortic stenosis caused by the subaortic septum. If without careful observation or lack of experience, it's easy to misdiagnose.

4. The prognosis of patients after operation was as follows, one patient developed III degree atrioventricular block early and installed permanent pacemaker. One patient had cyanosis and dyspnea and underwent mitral and tricuspid valve repair. One patient had severe mitral insufficiency in the early stage and underwent mechanical mitral valve replacement 3 days after operation. One case underwent resection of ALMR 9 years after the first operation. All patients had no in-hospital death.

5. Patients were treated with tolasemi tablets and potassium citrate granules after the operations. The surgical methods of inflow tract obstruction mainly include removal of ALMR, chordae tendineae release operation was performed, papillary muscle incision, and mitral valve replacement. The surgical methods for outflow tract obstruction mainly include aortic coarctation resection and end-to-end anastomosis, removal of subvalvular septum, etc. Among the 66 patients, 7 patients underwent secondary surgery. There were 4 cases of complete shone's syndrome and 62 cases of incomplete shone's syndrome.

Once again, I sincerely thank the two reviewers for their valuable comments !