

[2023-04-30]

Dear Editors:

We would like to thank you and the reviewers for the valuable comments and suggestions. We have reviewed our work again and have carefully revised the manuscript accordingly. We have provided our point-by-point responses below. We hope the revisions and responses meet the requirements of the *World Journal of Clinical Cases* and satisfactorily answer the questions and concerns of the reviewers.

### Response to reviewer's comments

**1. Reviewer's comment: Please make clear if these are witnessed arrests for patient's who arrest in-hospital - or if any were out of hospital arrests.**

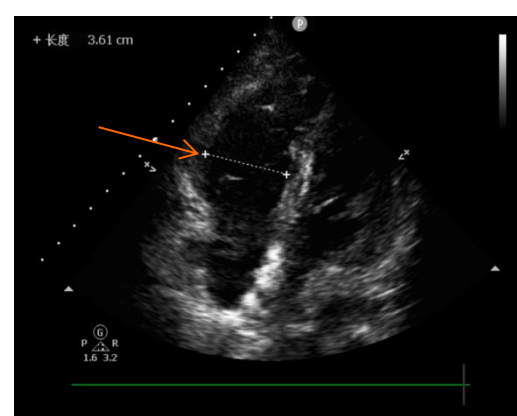
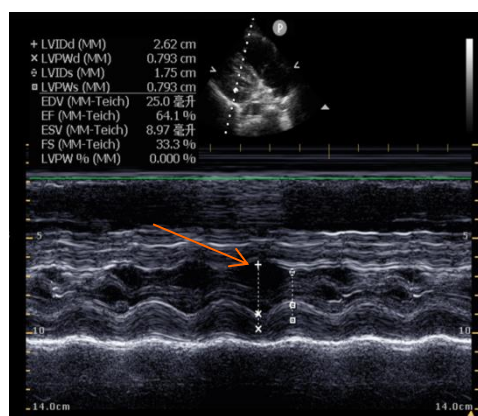
**Response:** All patients in this study experienced witnessed CA as the CA took place within the hospital.

**2. Reviewer's comment: Massive PE is the usual term.**

**Response:** We sincerely thank the reviewer for careful reading. As suggested by the reviewer, we have corrected "high-risk PE" to "massive PE".

**3. Reviewer's comment: Report echo-graphic evidence of RV strain.**

**Response:** Thank you for this helpful suggestion. We have added a representative echocardiogram as Figure 1.



**Figure 1 Echocardiographic examination of the patient in case 5.** A: Parasternal Long Axis View revealed that left ventricular end diastolic dimension was 26.2 mm; B: Apical 4 Chamber View revealed that right ventricular end diastolic dimension was 36.1 mm. Right Ventricle/Left Ventricle ratio > 1.

**4. Reviewer's comment: Are the researchers able to present time from decision to initiate ECMO to ECMO flow?**

**Response:** Thank you for raising this important point. The decision to initiate ECPR can be made following 10 minutes of CPR with no return of spontaneous circulation. However, due to the different conditions of the wards where the CA occurred in each patient, the time required for preparation of ECMO was not uniform and for some patients there was a delay of several minutes. However, from a review of the literature it became apparent that existing studies placed a greater emphasis on no- and low-flow time when optimizing the efficacy and neurological prognosis of ECPR. The results of these studies showed that shorter no- and low-flow times were associated with improved survival and neurological prognosis of patients receiving ECPR, which was consistent with the results of our study. Therefore, we chose to use low-flow time as the study indicator.