

Dear Editors and Reviewers:

Thank you for your letter and for the reviewers' comments concerning our manuscript entitled "Endovascular stent-graft treatment for aorto-esophageal fistula induced by an esophageal fishbone: two successful cases and a literature review" (ID: 63034). Those comments are all valuable and very helpful for revising and improving our paper, as well as the important guiding significance to our researches. We have studied comments carefully and have made correction which we hope meet with approval. We have send our revised manuscript to a professional English language editing company to polish the manuscript further. The main corrections in the paper and the responds to the editor's and reviewers' comments are as following:

Responds to the editor's comments:

(1) Response to comment: (The title of the manuscript is too long and must be shortened to meet the requirement of the journal (Title: The title should be no more than 18 words))

Response: It is really true as Editor suggested that the title of the manuscript is too long. We have made correction and shortened the title to less than 18 words according to Editor's comments.

(2) Response to comment: (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.)

Response: We have provided the original figures using PowerPoint file to submit on the system.

(3) Response to comment: (Authors are required to provide standard three-line tables, that is, only the top line, bottom line, and column line are displayed, while other table lines are hidden. The contents of each cell in the table should conform to the editing specifications, and the lines of each row or column of the table should be aligned. Do not use carriage returns or spaces to replace lines or vertical lines and do not segment cell content)

Response: We have submitted the Table on the system according to Editor's comments.

(4) Response to comment: (This manuscript has publication value, but the English writing of the manuscript needs to be further improved, and the writing of this manuscript does not meet the writing standards of our journal, and it needs to be carefully revised in accordance with the requirements of our journal)

Response: It is really true as Editor suggested that the English writing of the manuscript needs to be further improved. We have send our revised manuscript to a professional English language editing company to polish the manuscript further. And, the writing of this manuscript is carefully revised in accordance with the requirements of our journal.

We would like to express our great appreciation to you for comments on our paper. Special thanks to you for your good comments.

Responds to the reviewers' comments:

Reviewer #1:

(1) Response to comment: (The format of the paper should be reviewed. Case 1 should be described separately from the Case 2. Number of sections in each case presentation need to be reduced and the text need to become more fluent. )

Response: It is really true as Reviewer suggested that the format of the paper should be reviewed. We have made correction to meet the publishing requirements of the World Journal of Clinical Cases. And, Case 1 was also described separately from the Case 2. But, number of sections in each case presentation are hard to reduce, because the case presentation is required to include 'Chief complaints', 'History of present illness', 'History of past illness', 'Personal and family history', 'Physical examination', 'Laboratory examinations' and 'Imaging examinations' according to the requirements of the World Journal of Clinical Cases.

(2) Response to comment: (Abstract 'case summary' is approximate and imprecise . A more detailed description is suggested: i.d. 'success' is repeated three times in two sentences; 'series of further treatments'....; 'performed a successful hybrid treatment '... What the meaning of 'We hope that this will alert clinicians to management issues of AEF'?)

Response: We are very sorry that Abstract 'case summary' is approximate and imprecise. It is really true as Reviewer suggested that 'success' is repeated three times in two sentences, so we have re-written this part. But it is really true that the treatment of the two patients was similar. The two patients were effectively managed with combined means of endoscopic, medical (broad-spectrum antibiotic therapy, fasting, gastrointestinal decompression, etc) and endovascular stent-graft treatment. The main difference in treatment was that the first patient presented with hematemesis after endoscopic removal of the fishbone. Subsequently, the patient underwent endovascular stent-graft treatment. The second case was managed with endoscopic removal of fishbone with simultaneous endovascular stent-graft treatment, without any signs of hematemesis or melena. Moreover, the meaning of 'We hope that this will alert clinicians to management issues of AEF' is that the endovascular stent-graft treatment without combined thoracic operations could be a valuable alternative in some selected patients who had no obvious signs of infection. If patients with AEF and clinical signs of infection who are in critical physical condition that makes them at high risk for open surgery should be considered for endovascular surgery as a palliative treatment, or a temporary alternative until they are healthy enough to tolerate open surgery. We have deleted this sentence because it might be hard to understand. We thank for your thoughtful advice.

(3) Response to comment: (Manuscript: The description of clinical presentation should be revised, especially for the case 1: 'patient spat blood several times with a total volume of approximately 1000 ml and exhibited clouding of consciousness' ...does it mean that the patient developed hemorrhagic shock? How was it manage? The clinical events in the peripheral hospital and the re-admission after aortic bleeding is unclear. AEF is life-threatening complication and the discharge to a peripheral hospital should be avoided. The issue should be underlined in the discussion. According to such clinical complication, angioCT should be performed in all cases of foreign body removal, even if clinically asymptomatic. Please include this aspect in the discussion. Detailed characteristics of aortic endograft

are necessary, especially in length. In case of small aortic injury, a short endograft is mandatory in order to avoid paraplegia. Have you consider this aspect in your multidisciplinary approach?)

Response: It is really true as Reviewer suggested that the description of clinical presentation has been revised. The management of the patient at peripheral hospital is unclear due to a lack of medical records. But it might be that the patient was suffered from fluid resuscitation at peripheral hospital. So we simplify the description to avoid further misunderstanding. We have emphasized in our discussion that AEF is life-threatening complication and the discharge to a peripheral hospital should be avoided. And, we also have added the aspect of angio-CT to the discussion. Furthermore, we have described characteristics of aortic endograft (including its diameter and length). We considered the types of endograft in our multidisciplinary approach. Neurological injury after TEVAR mainly included paraplegia due to ischemia of the spinal cord and hemodynamic changes caused by endograft covering the left subclavian artery. Our vascular surgeons performed the vascular interventional procedures, and the type of stent selected was mainly based on the situation and location of aortic injury, so as to achieve the therapeutic effect and reduce the occurrence of paraplegia as much as possible.

(4) Response to comment: ('Broad-spectrum antibiotic therapy' insted of 'anti-infective therapy' What means: 'impaled aorta by foreign body was taken into account' 'The angiographic catheter was first guided into the thoracic aorta and arteriography revealed a 1 cm vascular niche in the descending aorta. Then an endovascular stent-graft had not yet been released after delivering to the selected location by a vascular surgeon. And then EGD showed that both ends of the fish bones inserted into the esophageal wall, 28 cm from the incisors (Fig 5A), and was endoscopically removed gently (Fig 5B) followed by active blood spraying noted in the esophageal defect (Fig 5C). ' ...difficult to be read and understood. How do you decide to restart the oral intake: can you give any message about this decision? In particular, did you repeat an endoscopy or a new CT or only by clinical signs?)

Response: We have replaced 'anti-infective therapy' with 'Broad-spectrum antibiotic therapy'. And we are very sorry that these sentences are hard to understand. So we have send our revised manuscript to a professional English language editing company to polish the manuscript further. We repeated a new angio-CT to decide to restart the oral intake.

(5) Response to comment: (Discussion: Redundant and vagous. Difficult to be read for many mistakes of English language. More concise concepts should be reported. What was the standard management before endovascular era? Please improve this section and report the rate of mortality and reinterventions. I do not understand your approach (and the take home message) to AEF secondary to foreignbody damage. Do you think that all these cases required TEVAR? Do you think that a CT scan after the removal of the foreign body and a close follow up may be an alternative, in order to avoid an overtreatment (even for the risk of graft infection and paraplegia).)

Response: We have polished our manuscript further and the 'discussion' had been revised according to the Reviewer's advice. At present, there is no uniform standard and consensus on the treatment of AEF. Surgical repair is the typical treatment approach and considered as the only definitive treatment for foreign body-related AEF before the emergence of endovascular treatment. A left thoracotomy followed by aortic replacement with a prosthetic/ cryopreserved homograft is a typical approach for

open AEF repair. We've also reported the rate of mortality and reinterventions. Not all these cases required TEVAR. Patients with AEF and clinical signs of infection who are in good physical condition that makes them at low risk for open surgery should be considered for thoracic surgery. Simultaneous or staged esophagectomy, aortic replacement and mediastinal debridement might have the reliability of better outcomes for patients with widespread inflammation and infection. We think that those patients who have undergone the removal of the foreign body and TEVAR therapy, but without combined thoracic operations, are necessary to undergo a CT scan and a close follow up, in order to avoid an overtreatment (even for the risk of graft infection and paraplegia). Conversely, we also consider subsequent thoracotomy as further treatment if there are any exacerbation of the condition. Even with long intervals between endovascular repair and subsequent thoracotomy, the patient's life may also be successfully saved. A author (Kelly SL, J Cardiothorac Surg, 2009) reported a successfully salvaged case that the patient's stent became infected after 51 days from single insertion of an endovascular stent-graft (excluding surgery) and subsequently definitive open surgical repair (involving removal of the stent, replacing the aorta with a homograft, reconstitution of the gastrointestinal tract, etc) were conducted successfully. Of course, we consider that these are only individual cases and more clinical experience are needed to confirm.

We would like to express our great appreciation to you for comments on our paper. Special thanks to you for your good comments.

Reviewer #2:

Thank you very much for your recommendation.

We tried our best to improve the manuscript and made some changes in the manuscript. These changes will not influence the content and framework of the paper. We appreciate for Editors/Reviewers' warm work earnestly, and hope that the correction will meet with approval. Once again, thank you very much for your comments and suggestions.