

Peer Review File

Article information: <https://dx.doi.org/10.21037/cdt-22-330>

Comment 1: Can you please add to the article (aorta remodeling)? So, more articles with direct measurements of the aortic volume after FET and not only information about the thrombosis and reinterventions. (doi: 10.21037/jtd-20-2356, doi: 10.1093/ejcts/ezv045).

Reply 1: We agree with the Reviewer that adding further details on aortic volume changes after FET would improve the manuscript.

Changes in the text: We have added an additional paragraph at the end of section 6.3 on pages 15-16 to discuss aortic volume changes after FET as requested and have included the advised papers.

Comment 2: The indication for CET or FET is not sharp. The FET operation requires more experience than CET, which many clinics do not yet have. Can you please discuss this as well?

Reply 2: We agree with the Reviewer that further discussion regarding the choice of CET or FET would be helpful.

Changes in the text: We have added an additional paragraph at the end of section 3.0 on page 6.

Comment 3: Although the number of non-standard abbreviations is not too high, it is better not to abbreviate spinal cord injury (SCI).

Reply 3: We agree with the Reviewer that spinal cord injury should not be abbreviated to improve readability.

Changes in the text: We removed the abbreviation (SCI) for spinal cord injury throughout the manuscript as requested.

Comment 4: Line 81: please add spelling of CET.

Reply 4: We agree with the Reviewer that this abbreviation should be expanded at first use.

Changes in the text: We have added the spelling of CET as requested.

Comment 5: Line 141: I recommend that authors comment on prevention of suture leak as a benefit of FET. Postoperative patent false lumen caused by new entry at the distal anastomosis site is associated with higher rate of distal aortic events. Use of FET can theoretically prevent new entry at the distal anastomosis.

Ref: European Journal of Cardio-Thoracic Surgery 52 (2017).

Reply 5: We agree with the Reviewer that FET can prevent distal anastomosis new entry by preventing suture leak.

Changes in the text: We have added text in section 3.1 on pages 6-7 commenting on the role of FET in preventing distal anastomosis new entry as requested.

Comment 6: Line 163: Implantation of FET can be performed quickly and prolonged CPB time is not long to cause deleterious effect. Rather, the reason why FET is not recommended in severely ill patients is that purpose of FET is a prophylactic surgery in some patients to reduce future distal events.

Reply 6: We agree with the Reviewer that FET may not be applicable in some severely ill patients since they may not survive to receive the full prophylactic benefits of the FET operation.

Changes in the text: We have added text at the bottom of section 3.1 on page 7 to highlight this.

Comment 7: Line 178: Please add FET-related issues in chronic dissection. FET is associated with higher incidence of distal stent graft induced new entry in chronic dissection compared with in acute dissection. Possible reason is that the intima in chronic setting is more rigid than in acute setting. Furthermore, sizing of FET remains controversial in chronic dissection. The true lumen is usually compressed by the false lumen, which makes appropriate sizing difficult. Ref) European Journal of Cardio-Thoracic Surgery 2022, 62(1), ezac325.

Reply 7: We agree with the Reviewer that further information on FET-related issues in chronic aortic dissection would improve the manuscript.

Changes in the text: We have added text at the bottom of section 3.3 on pages 8-9.

Comment 8: Line 254: Please describe which diameter of the descending aorta was used for sizing. True lumen or whole aorta?

Reply 8: At our centre, we size the FET stent-graft to measure 90-100% of the diameter of the entire descending aorta, not just the true lumen.

Changes in the text: No changes to the manuscript text have been made.

Comment 9: Line 257: Regarding distal FET landing level, we now recognize that T8 or beyond is a risk factor for SCI as shown in reference #78. Thus, I recommend removing the description that FET is delivered to the level of T8.

Reply 9: We agree with the Reviewer that it is now recognised that FET stent-graft delivery to T8 or beyond is a risk factor for spinal cord injury.

Changes in the text: We have removed the reference to FET stent-graft delivery to T8 in section 5 on page 11.

Comment 10: Line 268: Do you mean that radiologists are one of aortic team members for sizing of FET?

Reply 10: At our centre, we often consult a vascular radiologist pre-operatively for their valuable interpretation of the CT scan, and their assessment of aortic and true lumen diameter on CT scanning may serve as an adjunct when sizing the FET stent-graft intra-operatively.

Changes in the text: No changes to the manuscript text have been made.

Comment 11: Line 387: Please add some modifications of FET technique. Specifically, fenestration of FET is useful in selected patients to avoid supra-aortic vessel reconstruction and simplify surgery. AMDS device is a further modified FET, a novel partially uncovered stent graft. These modifications are expected to change surgery for aortic arch.

9. Refs: European Journal of Cardio-Thoracic Surgery 59 (2021) 765–772.
J Thorac Cardiovasc Surg 2019;157:1763-71.

Reply 11: We thank the Reviewer for this helpful suggestion and agree that further description of modifications to the FET technique would improve the manuscript.

Changes in the text: We have added text to section 7 on pages 16-17 commenting on novel modification of the FET technique as requested.