Peer Review File

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Comment 1: Please discuss this with other references
Reply 1: Thank you for pointing out this important issue. In light of your comment, we added a new reference and the sentence changed into " The prevalence of D-TGA is 0.02-0.05% of live births [2-6], and perioperative mortality is about 4% [7-8]. "
Changes in the text: see page 4, line 63-64.

Comment 2: The most important classifying of the d-TGA is for urgent and planned d-TGA. The ones which required urgent Rashkind procedure, and the ones which only required Prostaglandin intake. You have to raise this problem in the introduction.
Reply 2: We appreciate your insightful comments. Per your comment, we added the following sentence to the introduction section " It can also be classified as planned d-TGA which only need prostaglandin E1 for later surgery and emergent d-TGA which must be intervened immediately after birth [11-12] "
Changes in the text: see page 4, line 68-70.

Comment 3: There is no need to describe the typical anatomy correlation in the d-TGA.
Reply 3: We respectfully agree with you and appreciate your comment. We deleted all the description of typical anatomy correlation of d-TGA in case presentions.
Changes in the text: delete all the description of typical anatomy correlation of d-TGA.

Comment 4: What was the indication?
Reply 4: Thank you for highlighting this important issue. We explained the indication for cesarean section in case one presentation in sentence “At 37 weeks + 2 days, due to onset of labor, a cesarean section was performed.”
Changes in the text: see page 5, line 102.

Comment 5: How did you know which baby you should administer Prostaglandin E1?
Reply 5: Thank you for your critical review. We now explain how we make sure to administer Prostaglandin E1 in the sentence “Prostaglandin E1 was administered for twin A after echocardiography confirmed foramen ovale restriction in the delivery room”
Changes in the text: see page 5-6, line 106-108.

Comment 6: Which condition? I think the foramen ovale restriction, but it should be explained.
Reply 6: Thank you for reminding us of this important information. We explained the condition in the sentence as “Because of foramen ovale restriction, twin A underwent emergent atrial septostomy via the umbilical vein.”

Changes in the text: page 6, line 113-114.

Comment 7: Why?
Reply 7: We appreciate your insightful comments. We now explain in the sentence "At 36 weeks+ 1 day, cesarean section was performed due to onset of labor."
Changes in the text: page 8, line 165.

Comment 8: The most important classifying of the d-TGA is for urgent and planned d-TGA. The ones which required urgent Rashkind procedure, and the ones which only required Prostaglandin intake.
Reply 8: Thank you for your critical review. We added the sentence"Fetal d-TGA can be classified as planned and emergent, the former only need prostaglandin E1 for later surgery while the later must be intervened immediately after birth[11-12]." in the discussion section.
Changes in the text:see page 9,line 187-189.

Comment 9: Is this correct references? Please explain better the necessity of genetic diagnosis in d-TGA, especially in twin pregnancies.
Reply 9: Thank you for reminding us of this important error. We corrected the reference and added three references to explain in the sentence"Skoric-Milosavljevic D[21] et.al identified a susceptibility locus at 3p14.3, which is known for its important role in cardiac development. Of note, there exist suspect that d-TGA is polygenic inheritance[22-23]."
Changes in the text: page 10, line 208-214.

Comment 10: What is the conclusion from the cases from Table? any benefits of analyzing them?
Reply 10: Thank you for this insightful point. We added conclusion and benefits after analyzing these cases in the sentence "The prognosis of isolated d-TGA is promising with appropriate management. Analyzing of these cases gave insight to us on the intervention of d-TGA cases."
Changes in the text: see page 11, line 249-251.