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Peer Review File

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Reviewer A

Comment 1: Title - Use plural for the word "Fistula", i.e., either "Fistulas" or "Fistulae".

Reply 1: "Fistulas" has been added.

Changes in the text: We have modified the title as advised (see Page 1, line 2).

Comment 2: Authors - What department does Kaixi Liu M.D. belong to at Peking University Third Hospital?

Reply 2: Department of Anesthesiology.

Changes in the text: We have modified the text as advised (see Page 1, line 7).

Comment 3: Running title - "Aorto-tracheoesophageal Fistula" is not an accurate abbreviation for Aortoesophageal fistula and Tracheoesophageal fistula.

Reply 3: "Delayed Aortoesophageal and Tracheoesophageal Fistulas" is now used instead.

Changes in the text: We have modified the running title (see Page 1, line 14).

Comment 4: Line 24: "accidentally ingested" will sound better than "mistakenly ingested" as the original sentence would imply that the patient mistaken the identity of a piece of bone for soft tissue that is safe to swallow.

Line 25: If the removal of the FB was "successful", then there would not be any complications.

Line 27: "implantation" is not the correct word to describe "insertion" of jejunal nutrient tube.

Line 28: was able to "ingest" a liquid diet is better phrased with "tolerate". Alternately use "ingest liquid foods".

Introduction: Line 41", over a few weeks," instead of "gradually".

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Line 42: "and may provide clinicians with some experience and lessons" - this is a very vague statement.

Reply 4:

Line 24: We agree that "accidentally ingested" is preferable to "mistakenly ingested". (Page 2, line 27)

Line 25: We have revised "successfully" to "fully". (Page 2, line 28)

Line 27: We agree with the use of "insertion". (Page 2, line 31)

Line 28: We agree with the use of "tolerate". (Page 2, line 32)

Introduction: Line 41: We agree with the use of "over a few weeks". (Page 3, line 52)

Line 42: We have revised this statement to "may provide clinicians with some experience and lessons for treating these complications". (Page 3, line 53)

Changes in the text: We have modified the text (see Page 2, line 27; Page 2, line 28; Page 2, line 31; Page 2, line 32; Page 3, line 52; Page 3, line 53).

Comment 5: Case presentation

Major rewriting is required throughout to have a good chronological flow and explanation of events and interventions provided to the patient. For example,

Line 47: Which hospital is your hospital? There are 2 hospitals among the authors' affiliations.

Line 48: What was his presenting symptoms to have a need for emergency treatment?

Line 49: What was the size and shape of the FB? How was it impacted in the esophagus?

Line 50: How was the FB "loosened" or disimpacted from the esophagus? The bone seemed to have been fractured prior to removal. If so, you have to state it. How was the bone or the bone fragments physically removed? With a grasper or snare loop? Was a cap or a rubber sheath used to prevent laceration of the oesophagus during withdrawal of the scope?

Line 54: Why "abdominal pain" if the trauma occurred in the mid-esophagus? Why not "chest pain”? Why no “fever”?

Line 60-61: What was done during VATS? I assume the indication is for mediastinal infection but was there an abscess in the mediastinum? Were drains placed inside the mediastinum?

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Line 62: "4cm from the left subclavian artery" Is it proximal or distal to the origin of the artery?
Line 64: Stent was inserted from the left clavicle (clavicle is a piece of bone)??? To the distal end of what??? Please describe the anatomy accurately so that a reader can make sense from what you are trying to say.
Line 66: What is anti-infection?
Line 70: What is the "scope" of TEF continued to expand?
Line 73: …horrible experiences caused by (complications of penetrating) FB

Reply 5:
Line 47: The hospital is the First Hospital of China Medical University. (Page 3, lines 56-57)
Line 48: His presenting symptom was difficulty swallowing. (Page 3, line 58)
Line 49: An elongated FB (approximately 3 cm) was observed to be supported at both ends of the esophageal cross section. (Page 3, line 61)
Line 50: The FB was gently loosened with a grasper. A cap or a rubber sheath was not used. Laceration of the esophagus did not occur during withdrawal of the scope. (Page 3, lines 62-63)
Line 54: The abdominal pain could be due to flatulence from routine aeration during gastroscopy or early complications related to the esophageal FB, such as the possibility of bone fragments falling into the intestine. Esophageal infection may cause fever, and AEF may cause chest pain. As the complications progressed, the patient developed these later symptoms. We warned the patient about early complications and reminded the patient to see the doctor immediately if abnormalities occurred.
Line 60-61: There was an abscess in the mediastinum. The drains were placed inside the mediastinum. I have added the process followed during the VATS. (Page 4, lines 83-88)
Line 62: It was inserted from the distal end to the origin of the left subclavian artery. (Page 4, line 79)
Line 64: The covered stent was placed from the aortic arch at the left subclavian artery level to the distal end of the descending aorta. (Page 4, lines 82-83)

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Line 66: The patient received intravenous fluid rehydration and anti-infection (imipenem-cilastatin sodium) treatment. (Pages 4-5, lines 73-75, 90, 98)
Line 70: The patient did not have a TEF at the beginning, but the TEF occurred as the complications progressed. When we found the TEF, the range was already 3*2 ㎝ at that time. (Page 5, lines 94-96)
Line 73: We agree and have made this change. (Page 5, lines 101-102)
Changes in the text: We have modified the text (see Page 3, lines 56-57; Page 3, line 58; Page 3, line 61; Page 3, lines 62-63; Page 4, lines 83-88; Page 4, line 79; Page 4, lines 82-83; Pages 4-5, lines 73-75, 90, 98; Page 5, lines 94-96; Page 5, lines 101-102).

Comment 6: Discussion
Line 86-87: Dysphagia is one of the Chiari triad that was omitted.
Line 91: Why must active surgical treatment of TEF happen only after the cough has resolved well? The cough may not resolve without surgical treatment.

Reply 6:
Line 86-87: Thank you for pointing this out; we have made this change. (Page 6, line 116)
Line 91: We intended to indicate that the patient should have been weaned off the ventilator and have a good cough reflex. (Page 6, lines 121-122)
Changes in the text: We have modified the text (see Page 6, line 116; Page 6, lines 121-122)

Comment 7: Figure 1
A. "Both ends" of the oesophagus means the upper oesophagus and distal oesophagus.
D. "Vasography" is radiography of the vas deferens! "Angiography" should be the correct word.
F and G show that the AEF was confirmed by tracheal CT (white arrow). Is it really AEF that is demonstrated or TEF that is demonstrated here?

Reply 7:

A. An FB was observed to be supported at both ends of the esophageal cross section. (Page 10, line 201)

D. We apologize for this error, which has been corrected. (Page 10, line 203)

F and G show that TEF was confirmed by tracheal CT (white arrow). (Page 10, line 204)

Changes in the text: We have modified the text (Page 10, line 201; Page 10, line 203; Page 10, line 204)

Comment 8: Others

Throughout the case presentation and discussion, the authors did not explain why the complications occurred at delayed timings, which is the very first word in your title.

The choice of the authors to submit this manuscript to Annals of Palliative Medicine is bewildering. The treatments given for the acute conditions described were all active and time critical and life-saving. None of them are really palliative in nature. Submitting your case report to APM is not suitable.

Reply 8:

We have added a discussion of why the complications occurred at delayed timings. We consider the stent for treating TEF a palliative treatment due to the dangerous status of the patient. A second surgery may be performed when the patient is stable.

Changes in the text: We have modified the text (see Pages 6-7, lines 126-135)

Reviewer B

Comment 1: Terrible complications followed each other. Despite all treatments, the patient is still in a high risk environment for possible recurrence and death. Stents are not acceptable for permananet treatment of aortoesophageal fistulas. They just can temporize the current condition and your patient will eventually develop massive bleeding if you will not make complete seperation of esophagus and aorta from each other. besides TEF is also another important problem.

I would not consider this patient as treated. Please follow him up very carefully.

I suggest you to develop plans for further problems.

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Reply 1: We agree with your opinion and thank you very much for your suggestion. At the time, we seriously considered the issue of stents, but the patient was in such a poor state of infection and nutrition that radical treatment was not suitable. We expect that further radical surgery will be performed when the patient is in a better state of infection and nutrition. We will develop plans for further treatment of this patient. Thank you very much！

Changes in the text: We have made the corresponding changes in the text (see Pages 6-7, lines 131-135).

Reviewer C

Comment 1: I congrate the authors on a nice written manuscript and a challenging case.
The text is generally well-written and the figure are of excellent quality.

I have some questions regarding the case itself.
When the foreign body was removed, did you perform a CT Scan? Did the CT have signs of early esophageal perforation? Air in the mediastinum?

The management of the aorto-esophageal perforation was flawless.
Nonetheless, I strongly disagree with the stent in the esophagus to treat the T-E fistula. It will gradually enlarge the fistula, and probably migrate into the Trachea. Furthermore, the stent in the esophagus side by side with the stent in the aorta increases the risk of erosion and bleeding. Thus, I personally would have treated this complication in other way.

Anyway, this does not diminish the quality of the paper. But I think that it deserves a more complete discussion, including the topics that I have mentioned.

Reply 1: Thank you very much for your suggestion.

Throughout CT and endoscopy, we did not find signs of early EP. Unfortunately, we did not re-examine CT after the removal of the FB.

We agree with your conclusion. In the long run, the stent in the esophagus is truly not suitable. At the time, we seriously considered the issue of the stent, but the patient was in such a poor state of infection and nutrition that radical treatment was not appropriate. We expect that further radical surgery will be performed when the patient is in a better state of infection and nutrition. We have added a more complete discussion in the text; thank you!

Changes in the text: We have made the corresponding changes in the text (see Pages 6-7, lines 126-135).