Peer Review File

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Reviewer comments

Reviewer A

Comment 1: The manuscript submitted by Christian Galata et al. describes the case report about open redo recurrent thymoma. I think it is challenging case. They reported not only preoperative evaluation and treatment in detail, but also operative finding of the challenging case.

Reply 1: We thank the reviewer for this comment and his interest in our case report. We agree with the reviewer that our manuscript covers preoperative evaluation, treatment, and intraoperative findings of this challenging case.

Changes in the text: None.

Comment 2: However, their paper didn't include novel surgical technique or approach, and didn't have any new information.

Reply 2: We thank the reviewer for this comment. We agree with the reviewer that our case report does not include a new surgical technique. However, it is our conviction that the introduction of new surgical techniques is not the purpose of a case report. New surgical techniques should ideally be developed under experimental conditions in the laboratory and should be introduced into clinical practice through prospective, randomized trials. Individual cases – which are by definition the scope of case reports – are rather not the setting for the implementation of new surgical approaches. Moreover, our case report represents a unique, individual case that comprehensively and instructively highlights current clinical aspects in thymoma surgery, which in our opinion justifies publication as a case report.

Changes in the text: None.

Comment 3: Moreover, the topics about iatrogenic bleeding from the aortic arch is undesirable and unacceptable as case reports of your journal.

Reply 3: We thank the reviewer for this very important comment that raises an important point. Reporting complications represents a serious conflict of interest for surgeons. This is especially true for intraoperative complications – such as hemorrhage from the aortic arch – which can potentially be attributed to technical errors and thus to individual failure. It is a great achievement of modern medicine that such complications are nowadays published in scientific journals. Our case report deals openly with the complication and describes the setting in which it was managed. Moreover, this complication can be classified as a so called "no harm" event, i.e., an error that occurred but did not lead to patient harm. It is exactly the underreporting of such events that bears the inherent risk of recurrence in different patients. It is therefore of great importance that such events are reported. We therefore are convinced that our case report will be of interest to the readers of *Mediastinum*. Please see also: McCafferty MH, Polk HC. Addition of "near-miss" cases enhances a quality improvement conference. Arch Surg Chic Ill 1960. 2004 Feb;139(2):216–7.

Changes in the text: To highlight this important issue, the following sentence was added to the DISCUSSION section of the revised version of the manuscript (lines 165-170, please see yellow mark in text):

The complication reported represents a "no harm" event, an adverse event that occurred but did not lead to patient harm. The underreporting of adverse events in surgery, especially of no harm events, bears the risk of recurrence in different patients. Comprehensive reporting and evaluation of surgical complications, including "near misses", remains an important issue in thymoma surgery.

Reviewer B

Comment 1: A paper is well written and concise, however, could you, please, explain the readers why the case is so unique that should be published? I am sorry, but I couldn't find anything innovative in your paper, perhaps it should be highlighted more clearly.

Reply 1: We thank the reviewer for this comment. Despite what is already highlighted in the DISCUSSION section of our manuscript, this case report focuses on an important type of surgical complication, a so called “near miss” or “no harm” event, i.e., an error that occurred but did not lead to patient harm. It is exactly the underreporting of such events that bears the inherent risk of recurrence in different patients. It is therefore of great importance that such events are reported. We therefore are convinced that our case report will be of interest to the readers of *Mediastinum*. Please see also: McCafferty MH, Polk HC. Addition of “near-miss” cases enhances a quality improvement conference. Arch Surg Chic Ill 1960. 2004 Feb;139(2):216–7.

Changes in the text: To highlight this important issue, the following sentence was added to the DISCUSSION section of the revised version of the manuscript (lines 166-171, please see yellow mark in text):

The complication reported represents a “no harm” event, an adverse event that occurred but did not lead to patient harm. The underreporting of adverse events in surgery, especially of no harm events, bears the risk of recurrence in different patients. Comprehensive reporting and evaluation of surgical complications, including “near misses”, remains an important issue in thymoma surgery.

Reviewer C

Comment 1: Nice case, but not unusual.

Reply 1: We are grateful that the reviewer appreciates our manuscript. Furthermore, we agree with the reviewer that the case is not unusual – unusual case reports are often uninstructive because they focus on rare, isolated cases. This case report, on the other hand, highlights the management of a complex recurrent thymoma that could occur at many centers around the world – in our opinion, this makes our article particularly instructive and worthy of publication.

Changes in the text: None.

Reviewer D

Comment 1: Galata et al. presented a successful case of open redo thymectomy for a large recurrent thymoma with myasthenia gravis. The authors insisted a conventional open surgery is still beneficial especially in complex cases such as redo surgery or infiltrative big tumor despite the era of minimally invasive surgery. Congratulations on the successful case of complex redo thymectomy. I deeply agree with the conclusion of the manuscript (…).

Reply 1: We are grateful that the reviewer appreciates our case report and deeply agrees with the conclusion of the manuscript.

Changes in the text: None.

Comment 2: I would like to know how the patient had been followed after the initial surgery until the diagnosis of the recurrence. When did the follow-up of this patient finish after the initial surgery? Do you have a standard protocol to see a patient with thymoma after the surgery in your institution? If so, how long do you see such a patient? And when did a regular follow-up by a neurologist for MG start? Isn't there any chance to take a CT scan for this patient in these 16 years? Probably, a normal chest X-ray can detect a mediastinal tumor of this size. I ask these questions because I believe there must be a chance to find the recurrence much earlier. Then the surgery would not be so difficult. I would like the authors to discuss the issue.

Reply 2: We thank the reviewer for these important comments. The patient was followed up by his neurologist in private practice after the initial surgery which was performed at a different institution. Imaging was performed regularly until 10 years after the initial thymectomy by MRI, with no evidence of recurrence. No further cross-sectional imaging was conducted between 2014 and the diagnosis of recurrence. At our institution, follow-up by cross-sectional imaging is performed every 6 months for 2 years for thymomas, and every 4 months for thymic carcinomas within the first 2 years, then every six months.

Changes in the text: We apologize for the misunderstanding regarding follow-up imaging. For clarification, the following sentence was added to the CASE PRESENTATION section of the manuscript (lines 77-78, see yellow mark):

The last cross-sectional imaging had been performed 10 years after the initial surgery and had shown no evidence of recurrence.

Comment 3: Why did the neurologist choose MRI as diagnostic imaging, not CT, when the patient had symptoms?

Reply 3: We thank the reviewer for this very interesting question. If we had followed up this patient, we would have done a CT in this clinical situation. However, the patient was not followed up by us, but by his neurologist in private practice. Upon inquiry, it turned out that the appointment for the MRI had already been made for routine follow-up when the symptoms appeared. For this reason, the already scheduled MRI was performed.

Changes in the text: None.

Comment 4: How was the initial operation? I would like to know the size of the tumor, the operation, and the margin. Were there any findings in the previous record that predict future recurrence?

Reply 4: We thank the reviewer for this question. Because the initial surgery was 16 years ago, the available data are limited. However, the patient underwent surgery for stage I thymoma in 2004. Thymectomy was performed via median sternotomy. The perioperative course was uneventful. The pathologist reported a T-lymphocyte-predominant thymoma with no evidence of malignancy. The capsule was intact on all sides. The initial surgical specimen had a weight of 48 grams and a size of 12 x 6 x 1.5 cm. The thymoma itself had a size of 2.3 x 1.9 cm. There was no suggestion of future recurrence. Follow-up was conducted by the patient's neurologist.

Changes in the text: None.

Comment 5: I would like the authors to describe the bleeding during the surgery more. How much were bleeding and blood transfusion? Where was the bleeding point? What procedure gave the damage to Aortic wall? Was that avoidable bleeding? Fortunately,

the bleeding stopped. But this could be uncontrollable. Maybe the authors should have considered CPB when they dissected a difficult portion.

Reply 5: We thank the reviewer for these questions. The bleeding occurred at the posterior wall of the aortic arch during dissection of the tumor. Preoperatively and intraoperatively, the surgical team was aware of this risk. For this reason, the operation was performed in standby of cardiopulmonary bypass. Fortunately, the bleeding was controlled quickly, and cardiopulmonary bypass was not necessary. The total blood loss of the operation was 700 mL. No transfusion of blood products was necessary.

Changes in the text: None.