
Peer Review File

Article Information: <https://dx.doi.org/10.21037/asj-23-30>

Review comments

Reviewer A

This is a common case report solved in a common way. CSSS is the traditional coronary steal scenario. The literature already is full of such reports, raising awareness of CSSS - even reviews of cases with outcomes, etc. A similar case with immediate cardiogenic shock was recently published in EHJ CR (<https://doi.org/10.1093/ehjcr/ytac490>). Moreover, a state-of-the-art pictorial review of all coronary steal scenarios was also published in EHJ (<https://doi.org/10.1093/eurheartj/ehad327>). In conclusion, the reviewer does not see how and what this report would add to the existing body of literature. The authors may wish to emphasize on that. For example, in the Abstract - Case Description, you don't even say how the case was solved and what was the outcome of the patient.

- Thank you for your review. We hope that with the extensive revision we have made on the advice of the editor and reviewers that you will find the manuscript to have an improved content.

Reviewer B

Dear Authors

Thank you for allowing me to review the manuscript entitled ‘‘ Intra-operative Coronary Subclavian Steal Syndrome’’.

The main goal of the study is to depict clinical outcomes in patients with subclavian stenosis undergoing LIMA-LAD anastomosis.

The main outcome is that the authors try do produce an algorithm for these patients? I have the following considerations and questions;

1) In view of the diagnosis, did any medical doctor or RN perform an Allen test in this patient? In case they did, was it normal or abnormal?

It was documented in the notes that the Allens test was normal with reperfusion in <5 seconds. We have added the following sentence into the manuscript: **Preoperative assessment revealed a normal Allens test with reperfusion of the hand in <5 seconds.**

2) Did this patient ever had any episode of syncope?

No episode of syncope was reported by the patient. We have not made any changes to

the manuscript in this regard.

3) What was the STS score of the patient?

In the UK we use EuroSCORE 2 currently. The EuroSCORE 2 was 1.87%. We have included this in the manuscript. The patients EuroSCORE II was calculated to be 1.87%

4) What was the EF? What was past medical history?

The patients EF was 62%. Past medical history as follow as included in the manuscript: Her past medical history included: obesity, a right hip replacement, tonsillectomy and depression. She was an ex-smoker with a 15-pack-year history and had a strong family history of ischaemic heart disease with both parents suffering ischaemic heart disease in their 40's.

5) What were risk factors for CAD?

As detailed above – smoking history, strong family history, obesity

6) What was the stent used for the left main? Was it DES?

She had a drug eluting stent. We have included this in the manuscript; had her left main stem stented with a drug eluting stent

7) How was LIMA harvested pedicled or skeletonized?

The LIMA was harvested pedicled with cautery – this has been included in the manuscript: The LIMA was harvested pedicled using cautery

8) Did you use cautery or harmonic scalpel to harvest the LIMA?

As above.

9) How was myocardial protection done? Antegrade cardioplegia and retrograde cardioplegia?

We have included the following sentence to explain this: Myocardial protection was performed with cold-blood cardioplegia administered antegrade into the aortic root, with repeat dose at 20 minutes and further cardioplegia delivered down the vein graft.

10) Was there any aortic regurgitation?

There was no aortic regurgitation.- included in the echo findings. Echocardiogram confirmed good left ventricular function with ejection fraction 62% and no valvular pathology

11) Did the patient had a nuclear scan prior to intervention to assess myocardial viability?

In view of the good left ventricular function, she did not undergo any viability assessment as per the protocol of our centre. . In view of the good left ventricular function no viability testing was performed

12) Where was LIMA anastomosed to the LAD?

The LIMA was anastomosed to the mid-LAD: anastomosed to the left anterior descending (LAD) artery in its middle third. The vessel was approximately 2.0mm and there was no mural disease at the site of the anastomosis

13) Was it anastomosed in the mid-LAD or distal LAD? What was LAD size target? Was it calcified? Was the anastomosis performed on a plaque?
As above for point 12.

We would like to thank reviewer B for their comments which have enriched the description of our case.

-