Peer review file

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Comment 1: So the first step is to improve the language, and the organization of the text.

Reply 1: Following the reviewers' advice. I contacted with one of my American friend, who went through the manuscript with me to correct much language flaw.

Changes in the text: I have modified the text.

Comment 2: I have questions about this point and mainly about the seven patients reported. How many of them had been previously operated from a type A dissection? This means that how many patients were considered for a redo surgery.

Reply 2: In our study, there was no patient who had been previously operated from a type A dissection. And these seven patients were owing to delayed diagnosis and surgical treatment with acute type A dissection. So there had no redo procedure in our study.

Changes in the text: No changes.

Comment 3: What were the symptoms of the patients with a chronic type A dissection?

Reply 3: Three patients had a history of hypertension; five patients experienced an episode of chest and flank pain several months ago. Five patients who initially presented with progressive dyspnea were referred to our hospital, and other two patients suffered mild chest pain.

Changes in the text: I have modified the text. (see Page 5, line 110-111)

Comment 4: Did they experience a visceral malperfusion syndrome?

Reply 4: There was no case who experienced a visceral malperfusion syndrome.

Changes in the text: No changes.

Comment 5: Did they have a significant dilatation of the descending aorta? This information is crucial to justify a surgical procedure.

Reply 5: I agree with the Reviewer. Preoperative CTA showed that the diameter of descending aorta was greater than 50cm (mean 5.2cm) in most of cases(5/7).

Changes in the text: These were described in the text, so there had no change .(see Table 1)

Comment 6: The manuscript is really poorly illustrated. It would deserve operative views showing the fenestration procedure since it is known to present surgical difficulties. On the same way, an operative view of compressive false lumen before the fenestration is also mandatory and might significantly provide information for surgeons who will read the manuscript.

Reply 6: Operative views would be more convincing, but unfortunately, we did not have record of operative views. Open fenestration of the proximal descending chronic dissection flap was done during intraoperative view of selective antergrade brain perfusion in 2 cases. And the length of septume excised was typically about 3 to 4 cm. Afterward of fenestration, a Dacron graft (about 2-3 cm length and the size same as tetrafurcate graft) was inserted into the true lumen of the descending thoracic aorta. In figure1(A), preoperative CTA showed a type A dissection with small true lumen at the descending aorta.

Changes in the text: No changes.(We described the procedure on page 6,line 136-141)

Comment 7: I would not say that the approach reported by authors is new and original since it has been previously reported yet with minor differences.There is a real interest to consider symptoms before leading these patients to a surgical approach.

Reply 7: Three patients had a history of hypertension; five patients experienced an episode of chest and flank pain several months ago. Five patients who initially presented with progressive dyspnea were referred to our hospital, and other two patients suffered with mild chest pain.

Changes in the text: I have modified the text. (see Page 5, line 110-111)

Comment 8: I completely agree with authors with the necessity of a preoperative serious and reliable imaging analysis before going further in the treatment as it is also known that an aggressive and perfect procedure can increase symptoms and worsen a stable situation.

Reply 8: In our opinion, the interval between the two procedures is determined by the condition of the patients' recoveration and illustration of postoperative CTA after the first stage procedure. If the CTA shows the diameter of the descending aorta is greater than 5.5cm and patient has a good recovery, the second stage procedure should be performed in time.

Changes in the text: No changes. (These was described on page 10, line 231-235)