

## Peer Review File

Article information: <http://dx.doi.org/10.21037/acr-20-100>.

### Review Comments

This case is very interesting. It may be the oldest patient reported so far. However, it is a pity that a lot of valuable information is missing, which dramatically reduces the clinical value of this article.

I suggest that the author collect as much information as possible in the CARE checklist, and then add it. Such as timeline, historical conditions, and the clinical value discovered in this way are all essential supplements.

We appreciate valuable comments from the reviewer. We tried our best to fulfill the CARE checklist as much as possible but we cannot avoid some missing details as the patient denied the follow-up. Please consider our explanation for some information which is missing in the checklist:

- Timeline: the patient spent 13 days of hospitalization without any changes in the treatment. She was discharged after recovery, then she denied the follow-up. Therefore, it is hard for us to present the case in the timeline.
- Historical condition: We could not track the patient's past hospitalizations as we do not have the inpatient tracking system in Vietnam. One of the most crucial details we could take from her past medical history is that she had no previous chest trauma or surgery. This information strongly supports the congenital coronary pulmonary artery fistula.
- Clinical value: We admit that the case has some limitations because 1/we could not confirm the entity with coronary angiography or coronary computed tomography due to the patient's renal problem, 2/the patient denied the follow-up. However, we provide clear evidences on the transthoracic echocardiogram which have never been reported elsewhere. To our knowledge, this is also the oldest congenital coronary pulmonary artery case report so far.

Comment 1: Please do not use any references in the abstract. The takeaway lessons/clinical value could be more practical and specific.

Reply 1: We have removed the references as recommended. The takeaway lessons we have mentioned in the abstract are: 1/congenital CPAF may be detected by TTE at a very old age, 2/the therapy for CPAF should be individualized (conservative management) because there is no current guideline as well as our patient is in advanced age and with multiple comorbidities. Besides we also provides the imagery of the fistula in both abstract description and video clip.

Changes in the text: the line 39 – 44, 54 – 55.

Comment 2: Add 'case report' as one of the keywords too.

Reply 2: we have added “case report” as one of the keywords.

Changes in the text: line 57

Comment 3: “13-CARE checklist' should be "CARE checklist". The introduction only shares the basic knowledge of the disease. Much vital information is needed regarding CPAF in the elderly, application of TTE in CPAF diagnosis, the proportion of success/failure of CPAF therapy, and present challenge. This information is all used for highlighting WHAT this case report ADDS to our knowledge.

Reply 3:

- We have edited the “CARE checklist” as requested.
- CPAF in the elderly: The congenital CPAF in the elderly is very uncommon. We carefully searched the literature and found out that the oldest congenital CPAF has been reported at the age of 83 by the angiography. We added this information in the introduction. Our patient is 10 years older than that patient at the time of diagnosis, and therefore could be the oldest case reported. Besides this, TTE makes our case more noticeable.
- Application of TTE in CPAF diagnosis: We have shortly mentioned the limitation of TTE in detecting CPAF (...“a few of them are identified on transthoracic echocardiography (TTE)”...), then we have explained more details about TTE in the discussion, including the poor acoustic transmissibility, two-dimensional imaging style, lower spatial resolution, and strong subjective judgment.
- The proportion of success/failure of CPAF therapy and the present challenge: Because the introduction should be brief, we did not provide much information about the treatment and the present challenge in this section of the manuscript. However, we have mentioned details about the therapy and the challenge of the case in the abstract and discussion.

Changes in the text: line 65 – 66, 69 – 71, 72

Comment 4: Please provide time details (date, month, year) in the case presentation. Each therapy should include medication name, dosage, duration details etc.

Reply 4: We have added the name, dosage, and route of administration of medications. We did not change any dosage during her 13-day hospitalization from January 11 to January 23 of 2017 (this time detail has been provided in the manuscript as requested). We also have included the name, dosage, and the route of administration of medications at home.

Changes in the text: line 98 – 102

Comment 5: As explained regarding the limitations, please present pitfalls in the discussion. One separate paragraph is suggested. An interesting point would be the TTE's value when coronary angiography/CT are not available (e.g. elderly, kidney issues, etc.). Discussion from this angle could further provide useful suggestions for peers.

Reply 5: According to the study of Jing-Lei Li et al which was cited, only 19.1% of CPAF cases are observed by TTE because of both objective and subjective factors. Therefore we admit that we were staggering and fortunate to have the CPAF detected via TTE, especially in this 93-year-old patient who could not have the angiography due to her poor renal function. We really wish to discuss more from this angle to make the case more useful for the peers. However it is tough to do so because even if we try to minimize the subjective factors, there are always objective ones which prevent us from identifying the fistula via TTE including poor acoustic transmissibility, two-dimensional imaging style, and lower spatial resolution. These points can explain for the dearth of CPAF detected by TTE and therefore, make our case fascinating and quite unique.