ANSWERS TO MANUSCRIPT REVIEWERS

Dear Reviewer #1,

I deeply appreciate your indepth review of the work. I would like to respond to the questions you raised in your review.

Query: please mention hemodynamic stability during VT (blood pressure).
Response: Thank you for your comment. The patient’s BP was stable at 122/98mmHg. I have included this in the physical examination portion of the case presentation.

Query: Which ICD was implanted (dual-chamber); it is unclear why amiodarone was stopped due to bradycardia unless he had S-ICD or single-chamber ICD.
Response: Thank you for your comment. The patient had a dual-chamber (RA and RV) AICD placed. However few months after VT ablation and after device check revealed no recurrent episodes of VT, it was decided to discontinue Amiodarone due to persistent bradycardia, markedly prolonged QTc and the increased risk of polymorphic VT (Torsades). This has been updated in the manuscript as well.

Query: Was intraoperative substrate mapping performed to guide ablation; or the latter was guided by anatomical landmarks. Please clarify and discuss. -
Response: Thank you for your comment. VT Cryoablation was guided by anatomical landmarks and was performed from scar area to the posterior mitral annulus (around P2/3 area) both from the LV endocardium side and epicardium side during the MV replacement procedure. Intraoperative substrate mapping was not performed and the operative notes do not specify the reason for the choice made.

Query: How was the LAD lesion during first coronaryography? discuss the option to treat.
Response: Thank you for your comment. During the first coronary angiography, the proximal, mid and distal LAD were within normal limits. During the second angiography, a mid-LAD lesion with 75% stenosis was visualized. Intravascular ultrasound (IVUS) catheter demonstrated a fibrofatty plaque with an area of plaque rupture. Lesion was dilated and 3.5 x 33mm DES placed, with final 0% stenosis and TIMI 3 flow.

Query: CT imaging was performed before ICD implantation. Discuss this imaging modality vs. cardiac MRI in this case
Response: Thank you for your comment. In this case, due to unknown magnetic resonance imaging (MRI) compatibility of the patients orthopedic implants (shoulder and knee), it was agreed to obtain a cardiac gated coronary CT angiography (CCTA) scan as opposed to the gold standard for LV aneurysm diagnosis, which is cardiovascular MRI.

Query: Discuss the role of wearable ICD in this clinical setting; and when i it is advised

Response: Thank you for your comment. Indications for the wearable defibrillator have been added to the discussion with the reference. Notably ischemic cardiomyopathy with an LVEF ≤35% within 40 days of an acute MI, within 90 days of coronary artery bypass graft (CABG) or new onset potentially reversible nonischemic cardiomyopathy as well as severe heart failure awaiting heart transplantation. The indication for patients who need an ICD temporarily explanted was not listed as it did not relate to this patient.

Query: persistent inferior ST elevation is consistent with aneurysm.

Reply: Thank you for your comment. This has been added to the manuscript

Query: In figure 4: letters A and B do not seem necessesary.

Reply: I agree with your comment. And have consolidated both pictures into one Figure

Query: When describing ECG in SR or VT please refer to the related figures

Reply: Thank you for your comment. I have done this for the EKGs reported in the manuscript. However, I did not include the image of the post-VT EKG described in the treatment portion as I did not believe it would add significantly to the overall educational content of the case.

Warm regards,
Anderson Anuforo
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