## Review Form 1.6

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| Journal Name: | **Journal of Pharmaceutical Research International** |
| Manuscript Number: | **Ms_JPRI_71084** |
| Title of the Manuscript: | **ANAESTHETIC MANAGEMENT OF A PREGNANT PATIENT WITH REPAIRED VENTRICULAR SEPTAL DEFECT- A CASE REPORT** |
| Type of the Article | |

**General guideline for Peer Review process:**

This journal's peer review policy states that **NO** manuscript should be rejected only on the basis of '**lack of Novelty'**, provided the manuscript is scientifically robust and technically sound.
To know the complete guideline for Peer Review process, reviewers are requested to visit this link:

(http://peerreviewcentral.com/page/manuscript-withdrawal-policy)

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**PART 1: Review Comments**

| | **Reviewer's comment** | **Author's comment** *(if agreed with reviewer, correct the manuscript and highlight that part in the manuscript. It is mandatory that authors should write his/her feedback here)* |
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| **Compulsory** REVISION comments | GENERAL COMMENTS:<br>- LACK OF NOVELTY: This patient had a minor cardiac condition, which was fully repaired as per authors description. ECHO and other investigations confirm normal cardiac function. Fully repaired ventricular septal defect is classed as WHO CLASS I, according to modified WHO CLASSIFICATION, which means that there is no increase in maternal mortality and no/mild increase in maternal morbidity during pregnancy. This patient does not have any additional anaesthetic concerns and should be managed like any other non-cardiac patient, (except a couple of cardiology visits during pregnancy to establish/confirm the status) hence the case report does not add to the medical knowledge, nor does it help to create further research opportunity.<br>- CONSENT: The procedure of patient consent/ waiver of consent needs to be clarified in the script.<br>- Introduction lacks clarity and fails to build on why the report needs to be published.<br>CASE DESCRIPTION:<br>- Patient's exercise tolerance and functional status/NYHA Classification before the surgery, which is an important aspect of assessment in any cardiac patient, is not mentioned. | |
| **Minor** REVISION comments | REFERENCES:<br>- There are multiple issues with references.<br>- Reference # 2, 5, 8 and 13 are irrelevant and are not even related to obstetrics/ obstetric anaesthesia (These are about ulcerative colitis, diabetic nephropathy, nurses' perceptions and exercise training program respectively)<br>- Reference # 6 is thirty years old though the author is talking about challenges faced in the current age, as many patients with CHD reach reproductive age.<br>- Reference # 9- old and irrelevant reference. It's a case report from 1984 of a patient with mitral valve disease. Not only the cardiac and anaesthetic concerns are different, but management of such obstetric patients has completely changed over the last decade.<br>- Some statements in the introduction as well as in discussion, regarding facts and figures are lacking appropriate references.<br>- Most of the references are very old.<br>- New references are irrelevant.<br><br>LINGUISTIC ERRORS:<br>- There are multiple linguistic errors, spelling errors and the use of informal speech which needs revision.<br><br>- Author seems to be addressing the patient rather than the medical community in some areas e.g. 'Even if your Ventricular Septal Defect has been restored, your heart is not "normal." All born with a Ventricular Septal Defect are at risk for other heart issues for the rest of their lives. Some can happen years after the repair was made. Endocarditis, or inflammation of the heart's lining and valves, is one possibility. It is important that you speak with your Atherosclerotic Coronary Heart Disease heart doctor on how to avoid endocarditis. People who have had their Ventricular Septal Defect repaired can experience a sluggish, rapid, or irregular heartbeat'<br>- | |

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| **Optional/General** comments | - CLINICAL MANAGEMENT:<br>- Clinical management in Case reports are sometimes taken as reference by readers. Some aspects of clinical management given to patient are not according to the best practices, and need to be justified.<br>o The selection of type of Anesthesia is perfect. Spinal anesthesia is apt for this patient.<br>o The use of infective endocarditis prophylaxis which is not indicated in this patient as per both NICE as well as AHA guidelines.<br>o The timing and mode of oxytocin bolus is also controversial. International consensus statement on the use of uterotonic agents during caesarean section published in 2019 recommends the use of oxytocin at the time of delivery of baby and not at skin incision, in the form of IV bolus, followed by infusion.<br>o Calcium gluconate for uterine contractility is not a recommended practice in any patient.<br>o Routine use of tranexamic acid in a patient not expected to bleed excessively, is also debatable. The used dose is not recommendation. | |

**PART 2:**

| | **Reviewer's comment** | **Author's comment** *(if agreed with reviewer, correct the manuscript and highlight that part in the manuscript. It is mandatory that authors should write his/her feedback here)* |
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| **Are there ethical issues in this manuscript?** | *(If yes, Kindly please write down the ethical issues here in details)* | |

As per the guideline of editorial office we have followed VANCOUVER reference style for our paper.

Kindly see the following link:

http://sciencedomain.org/archives/20

**Reviewer Details:**

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