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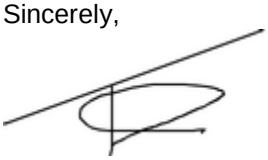
Dear Dr Fang-Fang Ji, Esteemed Editors and Reviewers,

Thank you for allowing us to revise and resubmit our manuscript entitled "*Atypical Presentation of a Hepatic Artery Pseudoaneurysm: a Case Report and Review of the Literature*" for consideration for publication in the **World Journal of Hepatology**.

Attached you will note the revised manuscript with tracked and accepted changes. We believe this manuscript is an unusual presentation of a hepatic artery pseudoaneurysm which required management by a tertiary care multidisciplinary team approach. Thus this manuscript provides educational value in the fields of interventional radiology, GI medicine, surgery, and pathology; all of which are highlighted. Thus we feel that the World Journal of Hepatology is the appropriate venue for presentation of our case report and review to the surgical community at large.

Please note our detailed response to reviewers below. We genuinely thank you for your consideration of this manuscript for publication in the **World Journal of Hepatology**.

Sincerely,



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Response to Reviewers

Reviewer #1:

The manuscript addresses an interesting and actually not so rare condition of hepatic artery pseudoaneurysm. The subject is addressed thorough the presentation of the interesting clinical case. Presentation is done in informative and concise manner. Article also gives a detailed description of possible therapeutic approaches. Therefore I recommend this article for publication.

Response to Reviewer #1: Thank you for your kind words and we appreciate your time and consideration of this manuscript.

Reviewer #2:

This manuscript presents a rare case of pseudoaneurysm of hepatic artery. The management of the case is informative, and useful for the readers. The pseudoaneurrysm was as diagnosed as Klatskin's tumor. The CT showed a low density area that suggested a tumor in the hilar part of the liver. Was magnetic resonance cholangiopancreatography performed? It is expected that MRCP showes the pseudoaneurysm in anatomical setting. Was ultrasonography performed? It is expectd that ultrasongraphy shows the pseudoaneurysm in detail. It seemed that the liver damage was due to the obstruction of bile duct. Was the obstruction recovered? Did the liver function normalize after the treatment?
Figure 3, 4: Scale bars are absent.

Response to Reviewer #2: Thank you kindly for your comments and questions regarding our enclosed manuscript. Yes, an MRCP was performed which demonstrated the tumor effect of the pseudoaneurysm. Further work-up studies such as ultrasound confirmed the location and extent of aneurysmal involvement. Multiple attempts to decompress the biliary tree were unsuccessful and fear of pseudo-aneurysmal rupture was always a concern. As you mentioned, continued biliary obstruction and lack of hepatic artery flow resulted in liver damage to right lobe of liver and after resection, the obstruction was removed en bloc with the pseudo-aneurysm. And yes, the patient had complete normalization of her liver function.

We apologize for the lack of attention to detail and thank the reviewer for pointing out the absent scale bars in Fig 3, 4. The scale bars have now been added.

Reviewer #3:

The abstract is quite concise, showing main important features discussed in the article. Case presentation is adequate: please specify if bilirubina normalized after biliary stenting. Role of imaging should be emphasized in the discussion; enhanced CT acquisitions and MRCP should be recommended in order to reach the correct diagnosis; I think that invasive procedure such as ERCP should follow a Non-invasive assessment of disease using CT and MRCP (outside institution management caused misdiagnosis in your cases). References are adequate.

Response to Reviewer #3: Thank you very much for your kind words, comments, and questions. Multiple attempts were made to alleviate the hyperbilirubinemia per endoscopic and transhepatic means. Unfortunately, the patient did not have resolution of hyperbilirubinemia and continued cholangitic events that threatened her life. We agree that appropriate imaging should be performed to assure the correct diagnosis before any invasive intervention is performed. Thank you for the comment and we have added this (below highlighted in red) to our discussion.

"Recent increases in the incidence of HAPs have been attributed to a rise in the number of liver transplantations, percutaneous liver and gallbladder interventions and the use of laparoscopic surgery[1, 4, 9, 11]. Advances in imaging techniques have enhanced the detection rate of asymptomatic HAPs[1]. While HAPs may be an incidental finding in an asymptomatic patient, more commonly patients present with abdominal pain, anemia, hemobilia, melena, and can present as life-threatening hemorrhage following

rupture[2, 8, 11]. Although we advocate interventional attempts such as angioembolization or stenting to stop hemorrhage immediately, failures in these attempts or chronic sequel on adjacent structures such as the biliary system and portal vein can require further investigations with possible surgical intervention. We advocate the use of non-invasive assessments, such as CT and/or MRI-MRCP radiographic imaging, to determine the possible etiology of biliary obstruction with then focused therapies toward alleviating the problem. To our knowledge, this is the first presentation of a patient presenting with classic picture of a Klatskin's tumor, specifically jaundice and pruritis secondary to biliary system compression by HAP that could not be managed with a non-operative approach. This unique presentation and atypical history for HAP initially masked the diagnosis. Despite a thorough diagnostic workup, no identifiable cause was uncovered for this patient's HAP, which further adds to the complexity and atypical nature of the case."