Answering reviewers

To the Reviewer 00053888

1. *The authors have provided a conclusive survey of aetiology and management of acute pancreatitis is Japan. There is an awful lot to commend this study in it's own right but when we are able to see trends in acute pancreatitis over such a long period of time in one country then the value is certainly added. The manuscript should definitely be shared with the HPB/general surgical community.*

-Thank you very much for your favorite comments.

To the Reviewer 03475347

1. *Your manuscript really contains novel and indispensable data for the revision of the severity assessment system for acute pancreatitis.*

-Thank you very much for your favorite comments.

To the Reviewer 00070310

1. *This manuscript has reviewed management of acute pancreatitis in Japan. This manuscript is well written, and will be acceptable for publication except one. 1, Please impact epidemiological analysis in japan compared with other countries.*

-As suggested, we have cited the data of epidemiological studies from the United States and Netherlands; the incidence of AP in the United States was 10.6 per 10,000 person-years in 2009 and that was 14.7 per 100,000 person-years in the Netherlands in 2005 (ref 9 and 10). These results suggest that incidence of AP might vary among different populations. This point is stated in the page 6, last paragraph.

To the Reviewer 02823000

1. *What were the questions in the survey? The authors just said the survey was consists of 2 staged postal survey. I have to ask whether prognostic factors were evaluated properly. Most of the guidelines for management of acute pancreatitis suggested to evaluate the severity at the time of admission and 48 hours after the admission. I think the survey should have asked whether the severity assessment was done properly first.*

-As suggested by the reviewer, we have described the methods of the nationwide survey more in detail. The second questionnaire included etiology/symptoms, laboratory data, imaging findings, therapy, complications and prognosis. The laboratory data and clinical symptoms included in the prognostic factor scores as well as contrast-enhanced

computed tomography (CECT) imaging grade were primarily assessed at admission. These points are now stated in page 6, 1st paragraph.

2. *The authors said the severity assessment system was revised in 2008, and no validation was done. Can the authors mention whether the revised criteria was better than previous one?*

-Thank you very much for the important suggestion. The previous severity assessment system proposed in 2002 was more complicated than the 2008 system; it consisted of 5 clinical parameters, 10 blood test items and CT findings. In cases with severity score > 2, SIRS criteria and age should be considered in the severity score. Several reports have shown that the severity scoring system of AP (2008) is more useful and easier for the prediction of prognosis than the previous one (2002) (ref 14 and 15). Of note, diagnosis of severe AP can be performed by CECT grade only, which enables diagnosis of AP with low-prognostic factor score. These points are now described in page 8, 1st paragraph.

3. *It is interesting to see how the management of WON has been changed. I need to ask why pseudocyst was included in the analysis. It is known that the prognosis of WON is more severe than pseudocyst, they should not be taken together as the same.*

- We added explanation why pseudocyst was included in the analysis. Because the term “pseudocyst” had been often used to describe a condition resembling WON in Japan, patients with pseudocysts later than 4 weeks after the AP onset were included in this study. At the time of 2011 survey, the revised Atlanta classification for AP was not published yet and the term “WON” has not been well recognized in Japan. This point is now described in page 12, 2nd paragraph.

We hope that our paper is now acceptable for publication in *World Journal of Gastroenterology***.**

Sincerely,

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