March 5, 2020

Professor Jin-Zhou Tang
Science Editor
*World Journal of Gastroenterology*
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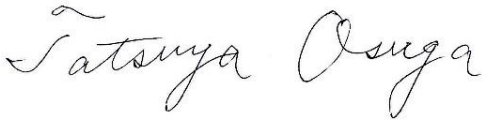
Dear Professor Tang,

Thank you very much for suggesting improvements to our manuscript.
We have revised the manuscript in accordance with the comments of the reviewer. Revised portions and new descriptions are highlighted in the revised manuscript. Detailed responses to the comments are given in the next two pages.
We hope that the revised version meets with your approval and can be accepted for publication in World Journal of Gastroenterology.

Yours sincerely,



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## Response to questions/comments

We sincerely appreciate the suggestions of the reviewer that were invaluable in revising the paper. Our responses to the questions/comments are as follows:

**#1:** How was it decided which patients would go into the surgery and which ones into the conservative management group?

→ As was described in the original text (page 6, lines 14-17), the presence of one or more CT findings, which include abdominal free-air, mesenteric artery embolism, lack of contrast enhancement of the intestinal wall and intestinal pneumatosis, was the sole criterion for a decision of surgery. To prevent misunderstanding, we have made a minor modification (three words insertion) to the sentence.

**#2:** Does the example of the 3/12 patients who would have gone to surgery had it not been for other comorbidities and who eventually still survived, raise any questions about the overall decision algorithm?

→ Yes. The experience of these three inoperable recovery patients motivated us to conduct the present study. Regardless of the CT findings, strategic conservative management may be recommended in the future for HPVG patients who have 0 or 1 of the high-mortality factors. To emphasize this concept, one sentence has been added to the Discussion section (page 15, line 24 to page 16, line 3).

**#3:** From the whole group, how many patients were persistently symptomatic, i.e. some patients may experience an episode of melena without abdominal pain or experience abdominal pain briefly which then resolves? How many had a milder presentation and how many a more acute?

→ Although no specific reason was recognized, our CT records did not contain HPVG cases that showed mild and/or transient symptoms. All 35 cases were of acute and serious illness (page 6, lines 10-12).

**#4:** The authors mention “shock” as a deciding factor: a) how do they define shock? b) if the patient was in shock, wasn’t that an indication to proceed to surgery, rather than manage conservatively? And c) at what point of the encounter did the shock appear, i.e. was it there from the beginning or did it appear later?

→ We defined “shock” as systolic blood pressure ≤90mmHg (a) that had been measured soon after the initial manifestation (c). We have stated the definition clearly in the revised manuscript (page 6, lines 11-12). The presence of shock did not influence the determination of surgical indication (b). Their circulatory status was conditioned by infusion before surgery (page 10, lines 4-6).

**#5:** Can the authors propose an algorithm regarding the management of these patients?

→ Including shock status, patients with two or three of the high-mortality factors may become subjects of challenging surgery, regardless of their background conditions. We added this concept to the discussion (page 16, lines 3-4).

**#6:** What are the plans for validation studies?

→ We are planning a prospective study based on our algorithm (page 16, lines 4-5).

**#7:** Minor grammatical revisions (voluntary)

→ Several minor changes were made in the revised manuscript, and are highlighted in gray.