

**Dear editors:**

We would like to thank you for your help with this manuscript and thank the reviewers for professional comments. We sincerely appreciate for your careful reading and invaluable comments to improve this manuscript. We have revised the manuscript according to the comments and suggestions of reviewers, and replied point by point to the comments as listed below. All the changes have been highlighted in the text by red color. The revised manuscript has been edited and proofread carefully. All authors have read and approved the final revised version.

We hope that the revised version of the manuscript is now acceptable for publication in *World Journal of Clinical Cases*.

We look forward to hearing from you soon. If you have any queries, please don't hesitate to contact me at the address below.

Best Regards.

Yours sincerely,

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## **Responses to comments from editors and reviewers**

### **Replies to Editor:**

**1: The authors did not provide the approved grant application form(s).**

**Re:** Thank you very much for your careful review. We have uploaded the funding agency copies.

**2: The authors did not provide original pictures. Please provide the original figure documents. Please prepare and arrange the figures using PowerPoint to ensure that all graphs or arrows or text portions can be reprocessed by the editor.**

**Re:** We agree with your comment and apologize for our negligence. We have used the PowerPoint software to rearrange the pictures and uploaded them.

### **Replies to Reviewer:**

#### **Reviewer #1:**

**1: The sentence "We here report the first male case of BCA to be confirmed by pathology in our department. " should be changed accordingly.**

**Re:** We deeply appreciate your suggestion. We re-wrote the sentence in the revised manuscript as the following:

*This article reports the first male case of BCA in our hospital, diagnosed by our team and confirmed by pathological biopsy.*

**2: In addition, as a general rule of academic humbleness; pronouns such as; "our" "we" should be avoided as much as possible.**

**Re:** Thank you very much for your suggestion. We have dealt with this issue seriously and reduced the frequency of such words.

**3: In the "Imaging Examinations" section the authors describes a huge cystic mass arising from left liver lobe however they do not mention additional cystic lesions in right liver.**

**Re:** Thank you very much for your careful review. We greatly appreciate your help to make an improvement to this paper. We added the descriptions of the lesions in the right lobe of the liver to the “*Imaging examinations*”.

**4: The authors do not mention any perioperative frozen section analysis. The authors should elucidate how they manage to differentiate the diagnosis of BCA from BCA carcinoma.**

**Re:** Thank you very much for your suggestion. First, the patient had a postoperative pathological section, which was demonstrated in the “*FINAL DIAGNOSIS*”. Microscopically, the cystic wall was lined by a single layer of cuboidal and columnar epithelial cells (Figure 3), and attached to atrophic hepatocytes, with fibrosis, calcification, and inflammatory cell infiltration. It was consistent with a BCA.

According to various imaging modalities, BCA has less thick and more regular walls and thinner septum than BCAC, while the presence of solid nodular masses or major calcifications in the walls and the septa indicates malignancy. It is difficult to accurately distinguish BCA and BCAC, a definitive diagnosis requires pathological examination after surgical resection.

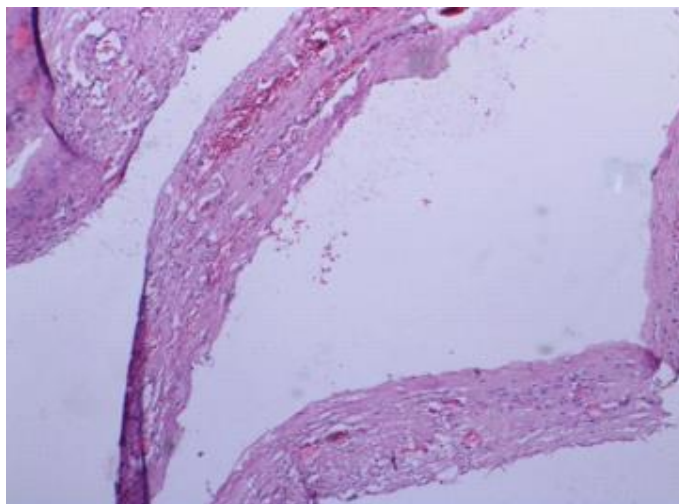


Figure 3 The pathological picture showed that the cyst wall was accompanied by monolayer columnar epithelium with fibrosis, calcification and inflammatory cell infiltration. Typical ovarian-type stroma was absent.

**5: The authors need to justify cyst fenestration for the treatment of this patient**

**rather than moving on with other treatments such as liver transplantation.**

**Re:** The BCA confirmed by biopsy needs to be completely removed to prevent recurrence and malignant transformation. Nonetheless, the general condition of the patient, anatomic position of the cysts and experience of the surgeon should determine the final choice of treatment. For this patient, grossly, the surface of the liver was covered with cystic masses, and the left lateral lobe of the liver had become completely cystic. There were many large blood vessels in the capsule wall. The cystic lesions sowed blurred outlines into the adjacent hepatic parenchyma, which made radical treatment impossible. On the premise of maximizing the resection of the lesion to prevent a recurrence, and meeting the patient's requirement for preserving part of the liver function, the surgeon performed left hepatic lobectomy, cholecystectomy, and liver cyst fenestration. It is strongly recommended that the BAC should be totally removed, partial excision should only be retained for those cases in which complete excision might endanger the main liver structures.

**6: Another important pathological feature of BCA is characterized by containing ovarian-type stroma that typically expresses estrogen and progesterone receptors (60-100%) hence; it is predominantly common in women. Was this finding positive for the presented case or not?**

**Re:** We agree with your comment and apologize for not mentioning this feature in the manuscript. We added this part to “**DISCUSSION**”. Histologically, the cystic walls are arranged from cuboidal to columnar epithelium and ovarian-type stroma is seen subepithelially, which is exclusively present in women and is immunoreactive for estrogen and progesterone receptors. In tumors in males, the supporting stroma is composed of fibrous tissue. The patient in our article lacked ovarian-type stroma but instead had fibrous stroma.