ANSWERING REVIEWERS

Dear Editor and reviewers,

Thank you for carefully reviewing our manuscript entitled **"A complicated course of biliary inflammatory myofibroblastic tumor mimicking hilar cholangiocarcinoma: a case report and literature review"** for possible publication in the World Journal of Clinical Cases. We greatly appreciate the reviewers' time and such a good evaluation. We have revised the manuscript, highlighting our revisions in red, and have attached point-by-point responses detailing how we have revised the manuscript according to the reviewers' comments below.

Thank you for your consideration and further review of our manuscript. Please do not hesitate to contact us with any further questions or recommendations.

Yours Sincerely,
Sandra Strainiene

ANSWER TO REVIEWER

Reviewer #1 (ID 02572474):

Scientific Quality: Grade A (Excellent)

Language Quality: Grade A (Priority publishing)

Conclusion: Minor revision

Specific Comments to Authors

Dear Editor, I appreciate the opportunity to be able to evaluate this manuscript. This is a rare case and it is well documented and deserves publication. I only suggest that the author discuss when there is and when there is no indication for surgical treatment. What are the limits for resection? It is necessary to clarify, what is the reason for chemotherapy.

Response:

Dear Reviewer,

First of all, thank you for such a good evaluation of our manuscript and your thoughtful and profound suggestions. We have supplemented our clinical case accordingly. We wrote the additional paragraph discussing indications for surgical treatment and limits for hepatic resection.

Please find below our answers and explanations about changes in the manuscript as a response to your remarks.

Indications for surgical treatment. Limits for hepatic resection

Despite reported successful treatment, complete reduction and tumor regression using a conservative approach (corticosteroids, NSAIDs, antibiotics, chemotherapy), tumors identified as IMTs by histopathology are locally progressive and often need surgical resection, especially if medical therapy is not effective [36, 37]. Although there are no approved recommendations for operative hepatobiliary IMTs treatment, the literature suggests that patients with resectable IMTs should be managed with radical surgical resection when it is anatomically and physiologically feasible [34 - 37]. The selection of liver resection candidates must be based on the patient's condition, tumor location, size and extension, the functional reserve capacity, and a sufficient liver remnant assessed by clinical and biochemical measures and by hepatic volume in cases of major hepatectomy [38, 39]. Complete resection of hilar tumors requires a partial hepatectomy or extended hemi-hepatectomy [39, 40]. There have also been some reports of a successful liver transplant, pancreaticoduodenectomy and combined liver transplant with pancreaticoduodenectomy in patients with hilar IMTs (**Table 3**) [1, 37].

Cases with hilar tumors are always challenging (particularly those in perihilar cholangiocarcinoma) as anatomically, these tumors in the hepatic hilum are in intimate relation with the portal vein and hepatic artery. Only about 1 in 5 patients with perihilar cholangiocarcinoma is eligible for surgery at the time of presentation [41]. The biliary extent of the tumor towards the segmental bile ducts is often more extensive than seemed on preoperative imaging [40].

The outcome of liver surgery during the past few decades improved. However, postoperative liver failure remains the leading cause of postoperative mortality. The assessment of hepatic functional reserve remains one of the most important issues in liver surgery [42]. The limit for "safe" liver resection is leaving a future liver remnant of at least 25% of the preoperative liver volume in patients with normal liver parenchyma or at least 30% to 40% in livers that are

compromised by steatosis, chronic cholestasis, cirrhosis or chemotherapy [40, 43, 44]. The potential risks and benefits of the surgery must be considered, especially when there are no established recommendations in the surgical treatment of biliary IMT.

Contraindications for liver resection are similar to those of cholangiocarcinoma and include: 1) patient factors (medically unfit for operation, cirrhosis/portal hypertension, malnutrition); 2) local factors (bilateral involvement of secondary biliary radicles, encasement or occlusion of the main portal vein, atrophy of one lobe with encasement of contralateral portal vein branch, atrophy of one lobe with contralateral involvement of secondary biliary radicles); and 3) distant metastases [40, 42].

In our case, radical surgical treatment was impossible as the mass was locally advanced - extending into both hepatic and some segmental ducts. Liver transplantation was also not an option due to the patient's age and recurrent infections.

The reason for chemotherapy

Based on the literature, chemotherapy is one of the possible treatment methods for IMT as it is defined as medium-grade sarcoma. There are cases in the literature where chemotherapy showed a good response. Therefore, after rigorous discussion with oncochemotherapists, it was decided to start chemotherapy with vinblastine and methotrexate, as other treatment methods showed no effect.