

Correction process. Point to point answer to the reviewers:

Reviewer #1

Grammar and language mistakes

The whole manuscript was revised, and grammar and language mistakes were corrected

Please revise conclusion is too long make it short and to the point

Conclusion was shortened and is now straight forward

"To our knowledge, this is the first case of successful endoscopic debridement of a SHH using a LAMS which appear to be feasible and safe in this specific case. Thus, EUS drainage of an infected SHH seems like an alternative therapeutic approach to consider, but clinical indications remain to be defined. More experience from other centers around the world will be needed before applying this treatment in a widespread fashion."

Reviewer #2

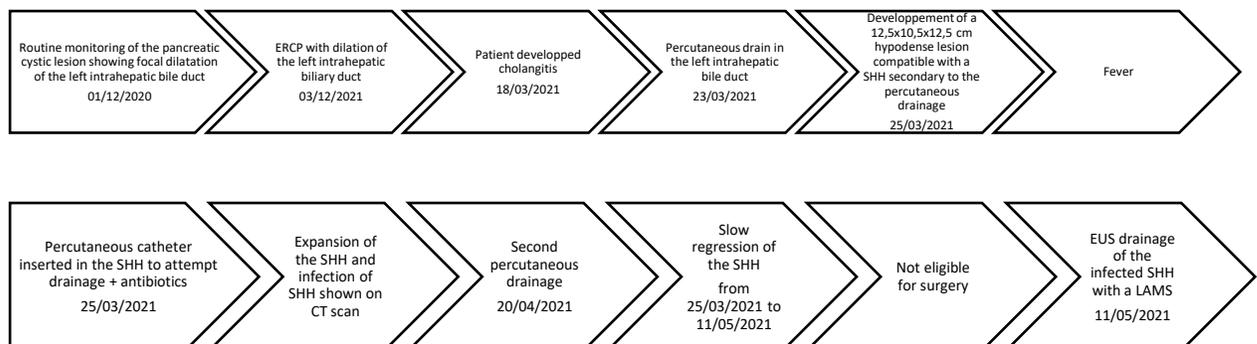
Please spell out SHH and WOPN in Introduction.

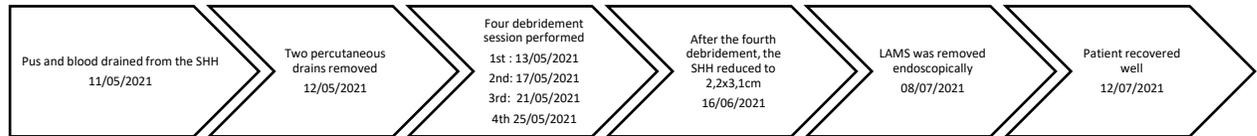
SHH and WOPN were spelled in introduction

It is hard to understand timeline in scheme. Please revise.

The timeline was revised and time labels were added

TIMELINE





The authors debrided four times. How long time did authors debride at a time?

The debridement sessions lasted 30 to 45 minutes each time with the patient under conscious sedation.

How about cost-effectiveness of EUS drainage compared with surgery?

We did not study the cost effectiveness of this approach compared to surgery. This is certainly an interesting question. Surgery remains for us the gold standard for refractory SHH; we proceeded this way because the risk of surgery was too high in our particular case

Please change the height and width of the photo in Figure 2.

Height and width of the photo in figure 2, was changed. Figure 2 is now smaller.

What are the tips for drainage technique in patients with an infected subcapsular hepatic hematoma?

The access technique and the debridement techniques are the same as any pancreatic necrosis debridement so the best tip is to have previous experience with those techniques

What is the specific complication for drainage technique in patients with an infected subcapsular hepatic hematoma?

Aside from the general risks related to endoscopic anesthesia (respiratory failure, aspiration), the specific risks are bile leak, bleeding, infection, perforation, peritonitis and death

Reviewer # 3

Is the surgical indication appropriate in this case?

The patient was deemed too sick to withstand surgery after evaluation by hepatobiliary surgeons. This information was already shown in the manuscript, but is now less ambiguous.

After consent from the patient, we decided to perform a EUS drainage of the infected SHH with a 10mm x 15 mm LAMS (Hot-Axios, Boston scientific) by a transgastric approach under conscious sedation.

The surgeons performed 4 times debridement. As mentioned “the patient couldn’t withstand surgery”, how to minimize the risk for the 4 times operation. The patient also need be evaluated for each time if he can withstand the operation. Details about each time like vital sign ,blood routine ,biochemical test,etal should be mentioned.

Since the patient couldn’t withstand surgery, there wasn’t any, just a classic upper endoscopic procedure under conscious sedation. Usual preparation was done on the patient before the procedure which does not include blood work, only 6h fasting.

Was the operation under general or local anesthesia ?

The procedure was done under conscious sedation

How to minimize risk such as bleeding, infection,cardiovascular accident from EUS operation itself?

Doppler was used before the first endoscopic access to avoid any vascular structure in the gastric wall. The SHH was scan with multiphasic acquisitions to rule out the presence of a pseudoaneurysm. The patient remained on large spectrum IV antibiotics from the first to the last endoscopic intervention to prevent supra-infection. We don’t think that the risk of a cardiovascular incident related to the procedures was significant. The patient was kept on prophylactic low-molecular weight heparin throughout his hospital stay.

“Endoscopic access to the SHH”.The access to SHH is “stomach smaller curvature”, right? How to minimize the risk of reflux of digestive flora into SHH?

This is a potential risk of all trans-gastric drainage techniques for which the consequences of benefits are unknown to our knowledge. Some have stated that it could be beneficial in the way that stomach acidity can provide a kind of chemical debridement (some even stop PPIs between sessions of pancreatic necrosis debridement); others fear potential supra-infection from the digestive flora. In our case, the patient remained on large spectrum IV antibiotics from the first to the last endoscopic intervention to prevent supra-infection. PPIs were maintained.

Details about preoperative preparation such gastrointestinal preparation should be mentioned

The patient was kept fasting for 6h before each endoscopic procedure

If some adverse reaction like peritonitis ,bleeding occur, how to deal with?

If significant bleeding was to happen, we would have referred to angiography and arterial embolization. For peritonitis, the decision to send the patient to the OR or to proceed with conservative management would have been based on the severity and extent on imaging studies.

Discussion section can be expanded further. No citation in discussion section. SHH is a rare complication. Analyze pathogenesis of SHH in this case.The relationship between “ EUS drainage and debridement” and pathogenesis of SHH in this case can be mentioned.

Discussion was completed, we added some citations and references. The pathogenesis of the SHH was explored explaining why percutaneous drainage failed.

Are there any studies about application of “ EUS” for group of patients that elders suffered from chronic diseases.

There is plenty of literature about the effectiveness of EUS gallbladder drainage for refractory acute cholecystitis in the elderly who cannot withstand surgery.

Could EUS be popularized for SHH in future? List the reasons.

We think that EUS should be considered along the other modalities (surgery, radiological drainage) for the treatment of all kinds of peri-digestive infections (pseudocyst, pancreatic necrosis, liver and perihepatic abscesses, acute cholecystitis). The choice of the best modality should be based on available scientific data, specific risks for the patient, local expertise, and availability of the technology.

Potential advantages of EUS are:

Less invasive than surgery

Larger stents and potential for later endoscopic debridement if needed

No need for a transcutaneous tube / collecting bag

Can be a permanent drainage (ex: gallbladders, pseudocyst)

Potential inconvenients are:

Lack of availability and expertise

Cost of material / technology

Provide some improvement idea for “ EUS drainage and debridement” for next time.

The use of a naso-cystic irrigation tube could be considered to do intermittent irrigation and aspiration. Those tube are used also for common bile duct infection but are not well tolerated by patients. The lack of specific endoscopic debridement instruments remains a challenge.

References to the article should be listed in a right order. One citation evolved excess references. “Endoscopic ultrasonography (EUS) has evolved making it more and more a therapeutic procedure [5,6,8,15,16].”

References are now listed in the right order and there are no more excess references

The discussion section contains some unnecessary repetition.“As mentioned earlier, SHH is a rare..... procedure.”

Unnecessary repetition were removed

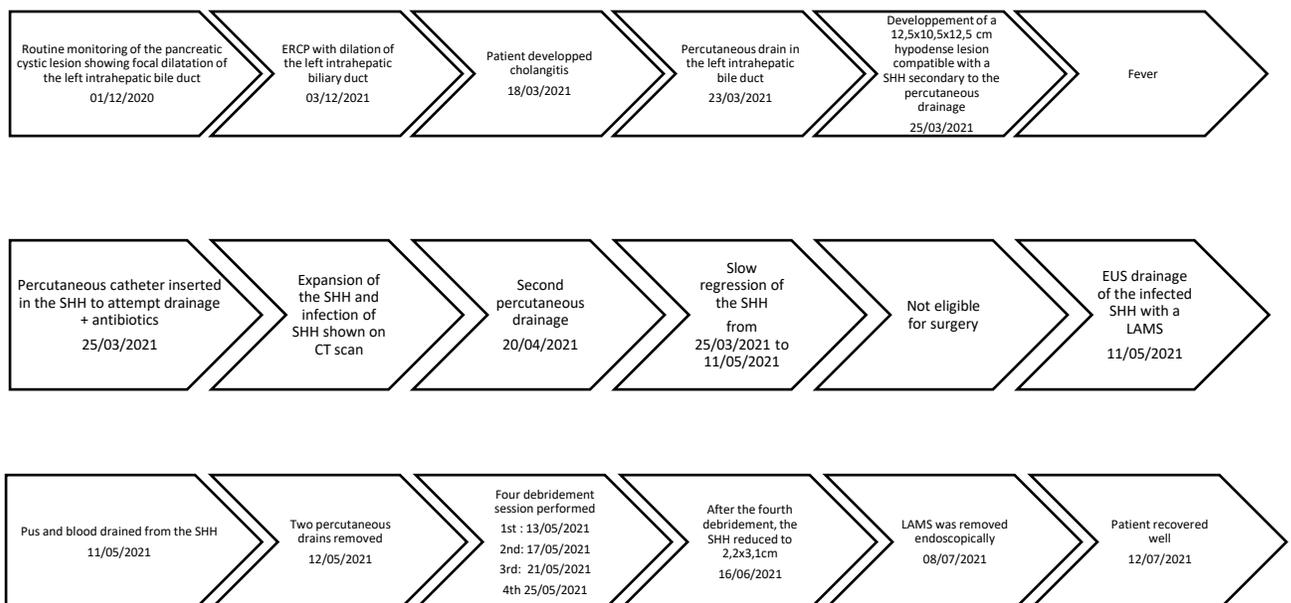
It could be better if indicated by arrows for “ (e) Endoscopic image showing debris of the hematoma inside the stomach after the last debridement”

Arrows were added in Figure II to better indicate the debris of the hematoma inside the stomach after the last debridement

It could be better provide exact time labels for “Timeline”. Different color for each debridement time point.

Exact time labels were added for every event in the timeline

TIMELINE



EUS drainage and debridement” performed 4 times. Informed consent should be required four times. There is only one signed paper. Authors should apply approval from their hospitals or clinic’s ethics board. Declaration of ethics should be represented in paper.

We have a signed consent for every endoscopic procedure that were done

Reviewer # 4

Dear authors and editors, Thank you for the opportunity to act as a reviewer of this manuscript. An extremely interesting clinical case is described in the treatment of which a non-standard approach has been tested. This is undoubtedly an achievement of the endoscopic technique and the specialists who used it. Having endoscopic experience of transgastric resolution of pancreatic cysts, it was possible to perform such a remarkable operation. The suppurated hematoma of the liver was resolved successfully. The anatomy of this area allows for such an operation, because 3 segment of the liver is attached to the zone of small curvature and the anterior surface of the stomach. The title reflect the main subject/hypothesis of the manuscript. The abstract summarize and reflect the work described in the manuscript. Key words used correctly, according to the content of the manuscript Background, methods and discussion written by the authors quite meaningfully. An endoscopic approach to the resolution of complex liver disease in a potentially inoperable patient has made for research progress in this field. Illustrations and Units, References were relevant and designed correctly. The style, language and grammar are accurate and appropriate. Authors should have prepared their manuscripts according to CARE Checklist (2016) - Case report. Ethics statements were observed by the authors, the patient's consent was obtained.

Thanks for your comments.

Reviewer # 5

No specific comments

Reviewer#6

The paper has been well revised.

Thanks for your comments.

Reviewer#7

This case report was well revised according with Reviewer' recommendation and suggestions.

Thanks for your comments.