Reviewer 1

1. The authors deal in this article with a realtive rare case regarding groove pancreatitis and as a consequence duodenal obstruction. The whole set up of the article is correct. The presentation of the case is well written. The necessar infromation regarding groove pancreatitis are provided. I disagree with the laparoscopic approach as primary surgical option for the patient. According to my opinion the authors should have chosen the open laparotomy from the beggining as a treatment option since they had to deal with an intestinal obstruction in a peritoneal cavity with vigorous inflammation load due to pancreatitis.

Thank you for your comment. We agree with your opinion. Since this patient had no clear diagnosis before the surgery and we aimed to perform exploratory laparoscopy to clarify the diagnosis. During the surgery, they found the horizontal part of the duodenum showed adhesion with mesocolon transversum, and it was hard to separate colon transversum and duodenum and open surgery was required.

Reviewer 2

Well written manuscript. Clinical case of notable surgical interest. The radiological documentation is exhaustive. The clinical history is well described. Exhaustive discussion.

Thank you for your comment.

Comments

1. The diagnosis is quite obvious when looking at the single pictures of the CECT scan and the decision to create an anastomosis with an inflamed duodenum is quite unusual. The latter decision have resulted in a prolonged and complicated postoperative period.

Thank you for your comment. Actually, the report of the first abdominal plain CT before surgery did not mention problems of pancreas. In the multidisciplinary expert consultation process, the professor from Radiology Department purposed the broadening of the groove region indicating probable pancreatitis. But the doctors did not recognize the diagnosis of GP until now. And after a long time of conservative therapy, the obstructive symptoms did not relieve and the surgeons recommended surgical exploration. And during the surgery, the diagnosis was not clear yet and intraoperative frozen section analysis showed no evidence of malignancy, so the surgeons performed side-to-side duodenojejunostomy in order to solve obstruction instead of pancreatoduodenectomy.

2. Listing the names of senior staff discussing the problem in the "multidisciplinary expert consultation" is also unusual.

I have revised the part as you advised.

3. Finally, the conclusion seems to have nothing to do with the presented case, proposing the reader to stick with the only radical option to treat this disease. Consequently it is not clear why it was not chosen in this particular case. A literature review would have been helpful discussing treatment options of Groove Pancreatitis.

Thank you for your comment. We have discussed the treatment options of GP in the sixth paragraph in discussion part. And in this case I think the difficult point is the diagnosis, the intention of this case report is to make GP more familiar to radiologists and clinicians, which will be helpful in making a

correct pre-operative imaging diagnosis and limit delayed diagnosis. We have revised the conclusions according to your comments. Thank you.