

Brussels, February the 16th 2015

Dear Editor,

Please find here the adapted version of our manuscript:

**Title:** Radioembolisation and portal vein embolization before resection of large hepatocellular carcinoma

**Authors:** Fikri Bouazza, Arthur Poncelet, Philippe Delatte, Jean Luc Engelhom, Maria Gomez Galdon, Amélie Deleporte, Alain Hendlisz, Bruno Vanderlinden, Patrick Flamen, Vincent Donckier.

**Name of Journal:** World Journal of Gastroenterology

**ESPS Manuscript NO:** 15840

The manuscript has been adapted according to the suggestions of the reviewers and recommendations of the editor. Revisions according to the reviewer requests are presented in red in the enclosed new version. English language has been deeply reviewed and is certified as grade A by the authors.

**I. Format has been updated**

- Authorship and institutions have been adapted
- Author contributions have been adapted
- Conflict-of-interest: none has been added
- Key words have been added
- The format of references has been modified
- Comments have been added

**II. Revisions have been made according to the suggestions of the reviewers**

Reviewer 3022391

- 1) The list of authors reflects the multidisciplinary aspect of the treatment in the present case. All listed authors participated in diagnosis and/or treatment, collected the data, and wrote specific parts of the report.
- 2) In cases of normal liver parenchyma, a minimal FRL/TLV  $\geq$  30% is usually considered as safe for performing a liver resection. In the case of liver disease (due to chemotherapy or cirrhosis), the necessary minimal remnant liver is not standardized, and depends on the severity of the liver damage. In the present case, the initial RLV/TLV-tumor volume (functional liver) was 30%. This ratio would be considered as insufficient by most groups, due to the presence of chronic liver disease. After radioembolization and portal vein embolization, this ratio reached 37%. Beyond the strict volume of the future remnant liver, we also considered the fact that, indeed, hypertrophy was obtained, underlining the regenerative capacity of the remnant liver. This factor, taken into account as part of the surgical decision, was added to the text (section case report, page 6).

- 3) With regard to the risk of tumor growth during liver regeneration, the potential benefit of this therapeutic sequence combining TARE followed by PVE has been underlined in the discussion (page 8).
- 4) English has been reviewed. The sentence about postop labs has been re-written. The citation of reference 9 has been corrected.
- 5) Preoperatively, cirrhosis was suspected on the basis of past medical history and, particularly, alcohol abuse and on the irregular aspect of the liver surface and segment I hypertrophy on imaging. This was added to the text (page 5).
- 6) LI-RADS and BCLC classifications have been added to the text (page 5).

Reviewer 2992398

No revision required.

Reviewer 70913

Surgical details have been added (page 6). Particularly, it is mentioned that no adhesions were found during surgery.

I remain,

Sincerely Yours,



Vincent Donckier