

Dear Editors,

Thank you for your comments as well as the remarkable suggestions and questions made by the reviewers. We have carefully revised the manuscript according to the comments of the peer-reviewers and editors. We changed **Authorship part**, and as editor's required, we marked **red font**.

All changed or revised in manuscript were marked with red font. And we reply to each reviewer's comments point-by-point.

We hope the reply would resolve the scientific issues raised by reviewers or editors and make the manuscript suitable for publication in WJG.

**Best regards,**

Chi Xu, MD

September 8 2016

Point-by-point reply to the issues raised by the Reviewers.

**Reviewer 1**

**1. How were the biliary anastomoses performed?**

Answer: In both cases, the methods of biliary anastomose was continuous anastomosis with absorbable suture. In the manuscript, we mentioned and marked with **the red font**.

**2. In both cases why did you not attempt balloon dilatation with a regular balloon after the failed PTCD first?**

Answer: In our primary manuscript (Case1 figure 3 and Case 2 figure 9) , we actually performed PTCD combined balloon dilatation. But we labeled unclearly. We apologized for the mistake and already corrected the labels and marked **the red font**.

**3. Can you mention details about the cutting balloon and technique?**

Answer: The cutting balloon system in two cases was manufactured by the Boston Scientific Corporation. Case 1: The patients with left position were sterilized on his abdominal skin. After the guidewire was successfully placed in right position, the Surgeon implanted the cutting balloon into stenosis site and inflated the balloon (diameter 6mm length 4cm; inflated pressure was 6 atm; dilatation time was 3mins). Subsequently the Surgeon consolidated cutting site with convention balloon dilatation (diameter 8mm length 4cm).Case 2: The patients with left position were sterilized on his abdominal skin. When the guidewire was successfully placed in right position, the Surgeon implanted the cutting balloon into stenosis site and inflated the balloon (diameter 5mm length 2cm; inflated pressure was 6atm; dilatation time was 3mins). Later the Surgeon consolidated cutting site with convention balloon dilatation (diameter 8mm length 4cm).

**4. Did you leave a stent after the dilatation?**

Answer: In both cases, we didn't leave the biliary stent. Because the cutting balloon treatment has advantage in relieving biliary stenosis, which is characterized by a high concentration of elastic and muscle fibers. We think leaving the stent after the cutting balloon treatment would be unnecessary.

**5. In your discussion can you mention if leaving a stent after cutting balloon dilatation helps maintain the newly gained diameter, and improves long term patency?**

Answer: The cutting balloon treatment is mature technology in the field of vascular surgery, meanwhile the treatment is rare applied in relieving biliary stenosis. It needs more clinical evidence to support. And it is hard to assess or compare the outcomes whether leaving the sent after cutting balloon dilatation. Hence our department would continue the research about the treatment of post-OLT biliary anastomotic stenosis.

Format of the article has been extensively modified and completed along with further addition of clinical data (all changed or supplied were marked with red font) which should assist with providing a more coherent and comprehensive review for the readers.