

Reviewer:

1- "methods" it would be good to specify the criteria for diagnosing FLNCC and if this was retrospective or were the histological slides reviewed again by an independent pathologist for confirmation that the criteria for diagnosing FLHCC is met, as often there is overlap between FLHCC and HCC

We have a separate pathology department and every case was confirmed by a dependant pathologist (a separate team) and the diagnosis was made as FL hcc. Our center is a large tertiary one specialized in hepatobiliary and liver transplantation. In that situations the difference between common HCC and FL HCC was made and confirmed by its pathologic criteria

2- The series is not a large one, but adequate given the lesser frequency of FLHCC) and is therefore difficult to comment about the statistics. However the finding of cirrhosis is unusual as most FLHCC occurs in normal parenchymal and it would be good to review the histology to confirm if the diagnosis of FLHCC in these 2 cases is correct.

This is an important point; as we said FL HCC arise in non cirrhotic liver, but two patients (9%) had liver cirrhosis due to hepatitis C viral infection while the remaining patients had a normal liver, we think that may be due to relatively high prevalence of hcv infection in our community or those two patients catch it during tumor development. Our pathologic team strictly confirm the diagnosis in these 2 cases.

3- There are two cases with positive margins and it would be interesting to review these for capsular wall thickness and invasion as FLHCC are often associated with encapsulation as part of the higher fibrous matrix activity

The safety margin was invaded in 2 (9%) patients who might be due to presence of the tumor closer to vascular structures which couldn't be resectable, we think in these two patients the tumor was located or even adherent to the right hepatic vein which made complete excision with safety margin impossible.

4- For the scan images, the authors need to remove patients' details and particulars for anonymity and also increase the labeling and markings to make the pictures more illustrative for readers.

We make these changes and an arrow was added to some photos.

Reviewer 2: COMMENTS TO AUTHORS

El Hanafy et al. present their experience in the surgical treatment of fibrolamellar hepatocellular carcinoma (FHCC), amounting to 22 patients (i.e., a sample size comparable to other series reported in the literature for this rare tumour). Two of these patients have hepatitis C/cirrhosis, likely by chance, given the prevalence of HCV infection in Egypt. I have the following comments/suggestions to improve the paper:

1. In a paper claiming to describe clinicopathological features of FHCC, it would be advisable to provide data on immunohistochemistry studies. Specifically, were specimens stained for cytokeratin 7 and epithelial membrane antigen? Were they positive in the cases with hepatitis C/cirrhosis?
2. In the introduction, no mention is made of the recent identification of a recurrent unique fusion gene between DnaJ/HSP40 homolog, subfamily B, member 1, and PRKACA (protein kinase, cAMP-dependent, catalytic, alpha [DNAJB1-PRKACA]), reported in FHCC but not in other HCC variants or cholangiocellular tumors. The Authors might not have had the chance to test their patients/archival material for this novel molecular signature of FHCC (otherwise, it would be important to present data), but they should at least comment on its discovery.
3. In the copy I had access to, due to some technical reasons Figures are not readable at all and Tables are messy.
4. A revision by a mother-tongue editor is absolutely

After consultation of our pathological department (in our gastroenterology and transplantation center) and also from the faculty of medicine, the diagnosis was made on its histological and pathological characteristics and they did not use all the mentioned recommendation to the diagnosis of FL HCC as the study was done over a long period starting from 1999.