

Dear editors:

We would like to contribute the revised manuscript numbered # 34011 entitled " Description of positive blood cultures among DCD donors and analysis of subsequent donor-derived infection among liver recipients in China" for consideration for publication in **World Journal of Gastroenterology**.

You have informed us that our article is not acceptable for publication without revisions that address each of comments.

We have revised our manuscript carefully according to Reviewer's comments. The revision address each of the following comments with our responses to each comment in parentheses:

Reviewer 1(02860897)

Donation after cardiac death is a potential source that increase organ donation, however, DCD have caused great controversy due to complication and survival rate. This report shows excellent result focusing recipient to donor infection. Control of infection is one of major issues in good clinical practice.

Major

1. Discussion is too long, summarize concisely.

(We shortened the section "Discussion" and made it concise.)

2. Description of organ donor is insufficient. At first, donor is should be divided according to Maastricht category and should describe the procedures for obtaining organs. Understandable table is helpful.

(1. We classified donation according to China Categories and found the majority (80.6%) of our donors belonged to China Category III which presented organ donation after brain death followed by circulatory death.We added the category of donors to Table 1.

2. After informed consent was obtained from the donor's family, life supports were removed. After the legal five minutes standoff time, the donor immediately underwent a "super-rapid" procurement technique in operating room. In brief, this included a rapid abdominal incision, rapid cannulation of the abdominal aorta and superior mesenteric or portal vein. The liver was perfused with the University of Wisconsin solution and prompt hepatectomy was performed. The intra-abdominal organs were removed en bloc and placed in University of Wisconsin solution at 4 °C then undergoing a subsequent period of cold storage. The bile duct was flushed with physiological saline solution in situ and preserved ex situ by University of Wisconsin solution.)

3. Please describe complications other than infection, especially ischemic biliary tract injury.

(Complications of all 67 liver recipients were summarized in an additional Table 4. A total of 20 episodes of infection complication being the predominant complication occurred in 3 liver recipients with donor-derived infection (4 episodes) and 64 without donor-derived infection (16 episodes), followed by 9 episodes of vascular complications occurring in 64 liver recipients without donor-derived infection. Six liver recipients without donor-derived infection underwent tumor recurrence.)

4. Add your infection control algorithm in DCD as perspicuous figure.

(We added our infection control method according to general standard. So we don't think a figure is necessary. We added our infection control method as follows: In a donor with a history or suspicion of prior bloodstream infection from whom a liver graft will be procured, a thorough investigation will be performed to insure that infection is not present in the liver. To rule out the presence of active infection, a detailed history from the donor's family and a complete review of medical records, vital signs, physical exam, radiographic studies and any

available microbiologic studies were obtained. Most of donors underwent routine cultures of blood, urine and sputum. Blood cultures will be obtained to rule out occult donor infection, especially among donors at “increased” risk for bacteremia or fungemia. The infected donor received targeted antibiotics for at least 24 h, with some degree of clinical response (improved WBC count and hemodynamics, defervescence) and, if possible, were treated with documentation of resolution of infection prior to donation.)

Reviewer 2(02855928)

1. Cardiac death donor is not familiar in some countries. For journal readers, add the survival curves after LTx, if possible.

(We added the survival curves in an additional Figure 1 which showed Kaplan-Meier curves for three-month survival after liver transplantation. No difference in survival was found between liver recipients with and without donor-derived infection using Log-rank test ($P=0.165$).)

2. Complications are summarized in the table. It is helpful for journal readers, because transplant surgeons know that infectious diseases in transplanted recipients often are uncontrollable, and refractory and/or intractable infections will cause not only sepsis but also various complications.

(Complications of all 67 liver recipients were summarized in the table 4. A total of 20 episodes of infection complication being the predominant complication occurred in 3 liver recipients with donor-derived infection (4 episodes) and 64 without donor-derived infection (16 episodes), followed by 9 episodes of vascular complications occurring in 64 liver recipients without donor-derived infection. Six liver recipients without donor-derived infection underwent tumor recurrence.)

Reviewer 3 (00504119)

Change the table 2 using descriptive data corrections.

(We changed the table 2 using descriptive data corrections.)