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## Answering Reviewers :

**ID 03563654:**

Thank you for your comments and questions.

1) Postoperatively, the patient is monitored in intensive care unit. A blood test is performed every day, with the assay of amylase in blood and in drainage fluid on the 3rd, 5th and 7th postoperative days. An abdomino-pelvic CT scan is systematically performed on the 7th postoperative day if a pancreatic fistula is present.
2) I completely agree with you.

**ID 03475779 :**

Thank you for your comments and questions.

I agree with you, complications of the PD and especially pancreatic fistula (PF) with its haemorrhagic (hematoma) and infectious consequences are well described in the literature. Liver failure in early or late postpancreatectomy have also been described in cases reports mainly. But to our knowledge, post-pancreaticoduodenectomy Budd-Chiari syndrome in has never been described.

1) PF was diagnosed from the 3rd postoperative day. PF was treated by somatostatin (6mg per day) and conservation of the non-aspirating drain placed intraoperatively.
2) To assess its dangerousness, we perform a systematic abdomino-pelvic CT scan on the 7th postoperative day in case of PF (in this case, it showed no active bleeding or pseudo-aneurism, and no hematoma, but the drain had migrated and was no longer in the area of the pancreatic anastomosis); and the assay of amylase in blood and in drainage fluid on the 3rd, 5th and 7th postoperative days.
3) Risk factors for PF are well described: Wirsung duct size ≤ 3 mm and soft pancreatic parenchyma (in this case, the patient was at high risk for pancreatic fistula). Preventative measures are also well described: Octreotide, stented pancreaticojejunostomy… (in this case, an internal stent was placed in transanastomotic and octreotide was started intraoperatively)
4) Postpancreatectomy haemorrhage is a seldom but serious issue, classified as early (before 48 hours) or late (after 48 hours and up to several days or weeks). Postpancreatectomy haemorrhage on the 12th postoperative day is a known issue. To our knowledge, there is no classification regarding the size of PF. Massive bleeding was difficult to predict because the patient did not have sentinel hemorrhage and the CT scan on the 7th postoperative day was normal.

**ID 03035498:**

Thank you for your comments and questions.

1) Yes, the patient had an emergency CT scan showing an active bleeding in the stump of the gastroduodenal artery.
2) There was the formation of a hematoma in the lesser omental sac, without any compression. The delay between CT scan and endovascular exclusion was approximately 3 hours, which may explain the increase of the hematoma becoming compressive on the inferior vena cava.
3) The morbidity state at 90 days was a moderate chronic kidney failure (grade 3). He is in good general status (performans status grade 0). Liver function is normal.

**ID 03548113:**

Thank you for your comments and questions.

We systematically drain the pancreatico-jejunal anastomosis by a non-aspirating drain, which remains in place as long as pancreatic fistula is active. The drain has not been removed. But on the CT scan on the 12th postoperative day the drain had migrated and was no longer in the area of the

pancreatic anastomosis, whereas on a control CT scan on the 7th postoperative day the drain was in place on contact with the anastomosis.
The initial drain was removed during the surgical recovery, then a new drain was set up.
Given the severity of haemorrhagic shock with hemodynamic instability, we chose to implement resuscitative measures without immediate surgical revision. Surgical revision was preferred to radiological drainage, because of the severity and high-speed liver failure.
Pancreatic fistula was treated with somatostatin.
Migration of the first drain, regardless of our decision, may explain the formation of an undrained hematoma.

**ID 02445477 :**
Thank you for you comments. Unfortunately, we don't have any intraoperative photo.