21 March 2019

Dear Editor,

Re: Reply to reviewer comments and revision of manuscript entitled "**Management of infected pancreatic necrosis in the setting of concomitant rectal cancer: A case report. "**

We would firstly like to thank the reviewer for their very kind comments. We also would like to thank the editor and reviewer for giving us the opportunity to revise our manuscript and to address some excellent points raised by the reviewer.

We will address each question/ point and will highlight this in our revised version of the manuscript.

1- Was the patient followed in the outpatient clinic after the first discharged?

He was meant to be followed up in clinic after discharge but had represented prior to this with infected pancreatic necrosis.

2. The PCR and imaging at the time of discharged showed that the pancreatitis has not been completely resolved. Do the authors considered to drain the pancreatic necrosis previous to discharge?

Given his clinical improvement such that he was off antibiotics and was on an oral diet - the plan at the stage of his discharge (6 weeks post admission on Day 42) was to allow the pancreatic necrosis to continue to mature and give this sufficient time (approximately 12 weeks following admission) to become walled off and accessible either endoscopically or surgically in the coming weeks to months provided there was no deterioration.

3- Pancreatic necrosis was accesible to drain through the stomach due to its location but do authors preferred endoscopic drainage over surgical drainage? Was the choice of endoscopic drainage made because of the location of the pancreatic collection?

Wherever possible the authors prefer a step-up approach preferring an endoscopic approach over surgery if this is appropriate and amenable to endoscopic drainage given the less invasive approach without the added insult and morbidity of surgery. In this patient this was even more relevant given the need to manage his rectal cancer expediently. The surgical approach was reserved as a step-up approach should the endoscopic approach have failed.

4. Does the diagnosis of rectal cancer changed any of the step-up approach management of the complicated pancreatitis? It seemed that the authors drained the collection because of the presence of a rectal cancer and the need of faster drainage and recovery instead of a true indication to drain the pancreatic collection.

The decision to drain the infected collection was primarily because he presented with infective symptoms with fever, rigors and raised inflammatory markers in the setting of new radiological evidence of infected necrosis with gas locules within the area of necrosis for the first time at just over 9 weeks post presentation.
The decision for intervention and drainage at this stage was that the necrosis was walled off and it was an appropriate time to intervene particularly in the setting of infected necrosis for drainage.
The presence of the rectal cancer made it crucial for us to adequately drain his infected collection, but endoscopic drainage at this stage would have been our approach even if the patient did not have a rectal cancer because the necrosis was sufficiently walled off the necrosis was mature.

We thank the reviewer for their insightful comments and questions and hope you will kindly consider our revised manuscript.

Yours sincerely,

Manju Chandrasegaram