

It would be necessary to clarify some aspects of the case.

1. Was there any intraoperative complication?

No complication. It has been added in our revised manuscript.

2. It would be interesting to know the body mass index of the patient (BMI).

The Body mass index of the patient was 24.90.

3. What was the size of the tumor extracted?

The tumor was 1.5 cm*1.3 cm in size. It has been added in our revised manuscript.

4. What was the surgical time?

The duration of the operation was 160 minutes. It has been added in our revised manuscript.

6. What type of prophylactic antibiotic was employed throughout the case?

Cefuroxime was employed as the prophylactic antibiotic.

7. It is necessary to specify more precisely the follow up time. From april 2009 till date?

From April 2009 to April 2013. It has been added in our revised manuscript.

8. It would be interesting to readers if the authors would summarize changes in their daily practice (change the stuff pancreatic closing?...use of RF-assited device to sealing pancreatic parenchyma?)

In our experience of laparoscopic distal pancreatectomy, pancreatic parenchyma was transected either by endo-GI alone, or by endo-GI closure with subsequent pancreatic stump suturing or sealing with fibrin-glue. However, the incidence of pancreatic fistula did not show significant difference. The RF assisted device was not employed in our practice. It has been explained in our revised manuscript.

This is a case report written quite friendly. Pictures are clear and help the text. My single suggestion is an advise from the authors to the other surgeons to prevent all these problems. What is their recommendation to avoid all those complications? And, do they have some more additional preventive approachs after this experience? Were they do any change in their sugical practice or not?

In the early stage of our practise of laparoscopic spleen-preserving distal pancreatectomy (SPLDP), large branches from splenic artery to the pancreatic parenchyma were carefully ligated and separated, while the small branches were severed by harmonic scalpel. We speculate that there may have been some “weak points” on the trunk of the splenic artery after SPLDP ---- origins of small branches from the splenic artery to the pancreatic parenchyma that were severed via harmonic scalpel without ligation. These “weak points” may be sensitive to erosion by pancreatic juice and thus were particularly prone to post-operative pseudoaneurysm formation. Therefore, we recommend that all visible branches between splenic artery and pancreatic parenchyma should be ligated and severed. It has been explained in our revised manuscript.