Dear editor and reviewers:

Thank you for reviewing my manuscript and making some comments on it. I have revised my manuscript according to the peer-reviewers' comments. As follows, I will provide specific point-to-point replies to each reviewer's comments

The first reviewer's code is **01220036** and his (or her) comment is "discussion is poorly written".

Replies to comment: Thanks for reviewer's comments and suggestions. According to the comments, I have revised the part of discussion. I herein present the way of my article writing. First of all, we introduce the definition and epidemiological situation of the disease. Because the review of literature is included in this paper. So next time, we present the methods of literature retrieval. Through making a summary of the previous literature, we further introduce the clinical features and imaging data of the disease. As a radiologist, I introduce the imaging features of the disease in detail, and then the treatment and prognosis of the disease. Finally, we make a reflection on this case, due to the lack of understanding of the disease, so that the patient's postoperative survival time is very short. For more information, please see the discussion section **(Line 195 to Line 253)** of the revised article. Thank you for your reading!

The second reviewer's code is **03563654** and his (or her) comment is "well written manuscript. i have few suggestions. 1- how is the follow up of patients? 2- "cholangiosarcom can have high comorbidities"(https://doi.org/10.1111/tbj.13174) AND (https://doi.org/10.1016/j.ijsu.2018.04.037) I suggest both of these up to date studies for the references".

Replies to comment: Thanks for reviewer's comments and suggestions. First of all, thanks again for the reviewer's praise.

Answer to question 1: We did the patient's follow-up by telephone once every three months.

Answer to question 2: I am sorry to do not understand the relationship between the two articles between cholangiosarcom. I have downloaded the two articles and read them in detail. I did not found the conclusion about "cholangiosarcom can have high comorbidities". So I did not add these up to date studies for the references.

The third reviewer's code is **00069105** and his (or her) comment is" Dear authors: The cases are very interesting but I have some concerns. I think that perhaps could be better to write cases separately because is very different to read the data of both cases together. I think that there is a cronological phase that is not complete. from radiology to pathology is surgery but no information about technical aspects, surical findings, type of hepatectomy, morbidity and so on. No information about adjuvant therapy The data of previous cases should be like a PRISMA study, databases, years, languages, restrictions, MesH, ... Possibly the search is perfect but is mandatory to include this information. PD: I think that as you said liver abscess was a very low diagnostic possibility, satellitosis, no fever, CRP normal, ... So all the comments about diagnosis as liver abscess should be erased ".

Replies to comment: Thanks for reviewer's comments and suggestions. After considering it thoughtful, I followed your advice and deleted a patient data**(see Line 122 to Line 192 for more information)**. Now, my manuscript is about one case and literature review. And I have added other data, including laboratory examinations, type of hepatectomy, intraoperative conditions and postoperative treatment**(see Line 142 to Line 149;Line 168 to Line 174; Line 187 to Line 188 for more information)**. In addition, I have provided the data of previous cases as shown in the **Table 1.** Since some of the previous cases were incomplete, I did not summary the data as PRISMA study. At last, we deleted some comments about diagnosis as liver abscess.

The fourth reviewer's code is **00189260** and his (or her) comment is" Interesting, unique case report".

Replies to comment: Thanks for reviewer's comments and praise.

The fifth reviewer's code is **03271124** and his (or her) comment is" Comments, 1. The part of patient data was not well written. The part of the case presentation should be re-write. The author should described the patient data in the better way as the following, - Case 1: • History • Physical examination • Laboratory data • Imaging • management - Case 2: 2. The laboratory data is not sufficient. What about the CBC? WBC? 3. Did you test the serum procalcitonin? If so, how about the procalcitonin value? Currently, procalcitonin would be the good predictor for infection. 4. What is the rationale for the liver biopsy of the first patient? 5. I think the Figure 3 would be MRI. The author should carefully review this point. 6. The most likely diagnosis from the MRI findings from the second patient would be cholangiocarcinoma rather than liver abscess. The T2 phase, the lesion is not clearly bright. The second case should not be the mimicking lesion. The author should be re-review with radiologists. 7. Did the patients perform the distant metastasis work up? CT chest or PET CT? 8. The patients underwent hepatectomy. The author should describe more data of the operation. Intraoperative findings? Anatomical or anatomical resection? Lymphadenectomy? 9. How about the short term outcomes? Complications? 10. The table 1 was not clearly data from previously report case. The format of the data is not easy for reader to understand. The summary table should re-write. The author should show the data from each previous report cases. 11. Due to the dismal prognosis of this kind of cancer. What is your recommendation if the patient was preoperatively diagnosis as SICC? 12. What is the new findings from this report?".

Replies to comment: Thanks for reviewer's comments and suggestions. **Answer to question 1:** **We** have revised the part of case presentation with the

following style: •Chief complaints, •History of present illness, •History of past illness, •Personal and family history, •Physical examination upon admission, •Laboratory examinations, •Imaging examinations. **(see Line 121 to Line 192 for more information)**

Answer to question 2: We have added the blood analysis were as follows: Red blood cells(RBC), 5.08*10^12/L（normal range:(3.5-5.5)*10^12/L）; white blood cells(WBC), 7.7*10^9/L（normal range:(4-10)*10^12/L）, platelet count, 149*10^9/L（normal range:（80-300）*10^9/L）. **(see Line 142 to Line 145 for more information)**

Answer to question 3: The results of procalcitonin was 0.04ng/ml (normal range:0-0.5 ng/ml). **(see Line 148 to Line 149 for more information)**

Answer to question 4: The rationale for the liver biopsy of the first patient is that the initial CT report presented a liver abscess and the tumor could not be excluded, so further biopsy was performed.

Answer to question 5: It was my mistake. I have edited it and carefully reviewed my manuscript.

Answer to question 6: We have re-reviewed the images of second patient. It presented hypointense on non-contrast T1 weighted images and hyperintense on non-contrast T2 weighted images. Some atypical liver abscesses can be presented the image like our case. We think that it was clearly bright on T2 weighted images. But the transient hepatic parenchymal enhancement following the enhancement was not significant. This was different from typical liver abscesses. In addition, the mass presented the honeycomb-like continuous enhancement. Base on the images, an atypical liver abscess could not be excluded.

Answer to question 7: Yes, the patient performed the CT chest examination after operation and there was not any evidence of distant metastasis.

Answer to question 8: We have described more data of the operation. The patient underwent non-anatomical hepatectomy and lymphadenectomy. **(see Line 168 to Line 174 for more information)**

Answer to question 9: We did the patient's follow-up by telephone once every three months. We could not provide the short term outcomes. When we do the first time of follow-up, the patient was passed away. We did not ask much questions so as not to arouse the sadness of the family to the dead.

Answer to question 10: We have provided the data of previous cases as shown in the **Table 1.**

Answer to question 11: If the patient was preoperatively diagnosis as SICC, we recommend that surgery as early as possible and postoperative chemotherapy are the better treatment. There is no evidence of evidence-based medicine at present to unify the treatment of the disease. So our recommend is that better treatment is surgery and postoperative chemotherapy.

Answer to question 12: The new findings from this report are as follows: simple surgery is not the better treatment of SICC; the SICC can present a multilocular cyst on radiological image and it is necessary to distinguish it from atypical abscess.