Reviewer #1: This is an interesting case report. Authors present a patient with upper GI bleeding resulting from cholecystoduodenal fistula. I have several opinions.

(1) This condition, cholecystoduodenal fistula, is a specific cholecystoenteric fistula. The condition in this case report has been classified as type V Mirizzi syndrome. Authors simply discussed their patient from the view of cholecystoduodenal fistula and had mentioned nothing related to Mirizzi syndrome. I suggest authors should expand their discussion in the point of view from Mirizzi syndrome. There are several relevant references related to this condition.

Thank you for your valuable comments. As you have commented, we failed to include type V Mirizzi in discussion section as cholecystoenteric fistula related to gallstone is an important pathologic cause of type V Mirizzi syndrome. We have added the following paragraph in discussion.

The pathogenesis of cholecystoduodenal fistula is unclear, but cholecystoenteric fistula as late complications of gallstone disease is known as type V Mirizzi syndrome. Pathophysiology for such complication is explained by mechanical pressure of gallstone that causes erosion of gallbladder and common bile duct wall due to impaction of gallstone that eventually results in formation of cholecystobiliary fistula. Recurrent episodes of gallbladder inflammation can also create fistula tract with other sites such as cholecystoduodenal, cholecystogastric, and cholecystocolonic fistulas.

(2) Since cholecystoduodenal fistula complicated with hemorrhage might be life-threatening, how to detect its existence before major complication? Dose any clinical hint to this condition? This should be important for clinician to learn how to identify cholecystoduodenal fistula since laparoscopic procedure can be conducted simply for cholecystoduodenal fistula

(cholecystolithiasis related) with satisfying result.

Thank you for your comment. We have added the following paragraph in discussion section.

As cholecystoduodenal fistula is a rare cause of massive gastrointestinal bleeding, clinicians should be aware of some signs that may help in differential diagnosis. Thorough history taking is always essential as history of gallstone disease may help in considering cholecystoduodenal fistula as differential diagnosis. It has been suggested by many authors that pneumobilia, a small atrophic gallbladder adherent to the neighboring organs, and a history of jaundice may indicate the presence of a cholecystoenteric fistula. Nonvisualization of the gallbladder, despite absent history of cholecystectomy, or the presence of a thick-walled shrunken gallbladder adherent to the neighboring organs, are reported as a suggestive finding of internal biliary fistula, especially the cholecystoenteric type.

(3) This patient had much stones in his gallbladder. Dose gall stone ileus be identified?

Thank you for your comment. The patient in this case report did not have gallstone ileus. We have added the following sentence in page 6 of "case presentation" section.

Ileus was not identified on abdomen X-ray or CT.

(4) How about the angioembolization regarding treatment for such condition?

Thank you for your comment. Changku et al (Hepatogastroenterology. Sep-Oct 2005;52(65):1372-4.) reported a case where embolization was attempted at first, but eventually surgery was done as leakage was not completely controlled with embolization alone. Thus, we have added the following paragraph in discussion section.

Angioembolization is another treatment to consider at available centers for identification and blockage of active bleeding of fistula that could not be controlled by endoscopic hemostasis. However, most fistulas are difficult to close up if recurrent cholecystitis is not controlled, and surgical management are usually required.