Response letter

Dear Editor and Reviewer,

Thanks for your comments and suggestions on our manuscript. We have carefully revised the manuscript accordingly. Hopefully this revision will make our manuscript acceptable for the publication in your journal. The following is the point by point response to the editor and reviewers' comments.

Editor's note:

1. The "Author Contributions" section is missing. Please provide the author contributions.

Response: Thank you for your kind suggestion. According to your comments, we have provided the author contributions.

2. The authors did not provide the approved grant application form(s). Please upload the approved grant application form.

Response: Thank you for your kind suggestion. According to your comments, we have uploaded the approve grant application forms.

3. The authors did not provide original pictures. Please provide the original figure documents. Please prepare and arrange the figures using PowerPoint to ensure that all graphs or arrows or text portions can be reprocessed by editor.

Response: Thank you for your kind suggestion. According to your comments, we have organized the figures into in PowerPoint files and upload them.

4. PMID and DOI numbers are missing in the reference list. Please provide the PubMed numbers and DOI citation numbers to the reference list and list all authors of the references. Please revise throughout.

Response: Thank you for your kind suggestion. According to your comments, we have provided the PubMed numbers and DOI citation numbers to the reference list and listed all authors of the references.

5. The “Case Presentation” section was not written according to the Guidelines for Manuscript Preparation. Please re-write the “Case Presentation” section, and add the “FINAL DIAGNOSIS”, “TREATMENT”, and “OUTCOME AND FOLLOW-UP” sections to the main text, according to the Guidelines and Requirements for Manuscript Revision.

Response: Thank you for your kind suggestion. According to your comments, We have revised the manuscript as suggested.

Reviewers' comments:

1. Authors should mention the possibility of heart failure at presentation. This differential diagnosis is supported by tachypnea, tachycardia, hemoptysis, hypotension and hypoxemia with high lactate 11.0 mmol/L. The patient was supported with breathing 100% oxygen concentration

with noninvasive positive pressure ventilation (NIPPV). The authors can provide the image of chest X ray to support/deny the diagnosis. Chest X-rays were characterized by multiple plaques in both lungs. Echocardiography showed enlargement of the left atrium, aortic sinus and ascending aorta. Systolic left ventricular function was impaired (ejection fraction 55%), but there was no pulmonary hypertension. Please provide chest X- ray and End Diastolic Volume to help exclude heart failure and diastolic dysfunction.

Response: Thank you for your kind suggestion. According to your comments, we have provided End Diastolic Volume. Considering the chest X-ray image was not clear, we submitted the chest CT image instead.

2. The abdominal aortic aneurysm was repaired first, and then the patient underwent laparoscopic left adrenal tumor resection? Please clarify the following: The aneurysm was supra or infra renal? Both were done at the same setting? What was the rational to start with repair of AAA, open surgery? Why not to operate the suprarenal mass first to avoid catecholamine surges and hemodynamic consequences? Please explain.

Response: Thank you for your comments. I am happy to revise and explain the problems. The aneurysm was located in the lower segment of abdominal aorta. In the preoperative period, there is an increased risk of rupture of the aneurysm, caused by excess catecholamine and

hypertension. Also, resecting the pheochromocytoma places the aneurysm at an increased risk of rupture in the postoperative period. Taking these factors into consideration， our patient was subjected to endovascular exclusion of abdominal aortic aneurysm first after strict blood pressure stabilization.

3. Other comments Abbreviation of Noradrenalin NA or NAD, should be unified in the table. Normal blood pressure was normal, and there were no other comorbidities or medication histories. Please delete “Normal”. The work up for leukocytosis, high cRP …? infection somewhere? It will be interesting to know how intraoperative management was carried out.

Response: We highly appreciate your constructive comments and suggestions. We have made correction according to the Reviewer’s comments and suggestions. Although initial laboratory tests demonstrated leukocytosis and significantly increased serum procalcitonin, there was no evidence of infection. So only routine prophylactic anti infective treatment was performed before operation.