

Dear Editors and Reviewers:

Thank you so much for your careful evaluation of our manuscript and the reviewer for the insightful comments. Those comments are all valuable and very helpful for revising and improving our paper, as well as the important guiding significance to our researches. We have studied comments carefully and have made correction which we hope meet with approval. Revised portion are marked with yellow in the paper. The main corrections in the paper and the responds to the reviewer's comments are as following:

Responds to the reviewer's comments:

Reviewer #1: 1. Please create a table summarizing 28 IPNB cases. 2. Did 28 IPNB cases show an increase in serum CEA levels as well as serum CA19-9 levels? Please add this point. 3. Please describe the resection procedure for 28 cases. 4. Of the 28 cases of IPNB in this paper, how many cases were able to be correctly diagnosed as IPNB before surgery? In addition, please clearly describe that this study dealt with cases diagnosed with IPNB by postoperative pathological evaluation. 5. This study included 11 cases with high-grade intraepithelial neoplasia and 17 cases with IPNB invasive carcinoma. Were there any differences in tumor markers or imaging findings between the two? I think it is also important to distinguish between the two before surgery.

Response:

1. Table 1 General information was added in this revision. The added tables can be seen on pages 8, 23 and 24 of the manuscript.
2. Serum CEA and CA199 levels of 28 patients were recorded in newly added table 1.
3. Surgical resection methods of 28 patients were recorded in newly added Table 1.
4. On page 8, lines 11 to 13, it was added that 4 patients were correctly diagnosed before operation. On page 8, line 18, it is added that 28 patients in

this study were diagnosed as IPNB by postoperative pathological evaluation.

5. According to the levels of CA199 and CEA in table 1, it is concluded by chi-square test that the proportion of CA199 positive patients in invasive cancer patients is significantly higher than that of patients with high-grade intraepithelial neoplasia, and there is a statistical difference. However, CEA is meaningless. There is no clear distinction between them in preoperative imaging. The modifications are marked in yellow on page 11.

The changes: Revised portion were marked in yellow in the paper. We have added Table 1 General information.

Reviewer #2: Please add a caption with per operative images, microscopic figures and explanatory radiological images.

Response: As Reviewer suggested that we added the images of choledochoscope during the operation, and added captions under the pathological pictures and image pictures.

The changes: we added the images of choledochoscope during the operation, and added captions under the pathological pictures and image pictures.

Reviewer #3: Comment 1 In case presentation, please provide proportion(%) of each number of cases. So, readers can understand the results more easily. Comment 2 All patients underwent intraoperative choledochoscopy. I think this is priority of this article. So please describe the procedure and images of intraoperative choledochoscopy.

Response:

1. In the case introduction, the percentage of the number of cases has been added.
2. We added the intraoperative picture of choledochoscope in Figure 2, and added a caption below the picture 2 to describe the intraoperative findings.

The changes: Revised portion were marked in yellow in the paper. We

added Figure 2 Choledochoscope images.

Special thanks to you for your good comments.

We tried our best to improve the manuscript and made some changes in the manuscript. These changes will not influence the content and framework of the paper.

We appreciate for Editors/Reviewers' warm work earnestly, and hope that the correction will meet with approval.

Once again, thank you very much for your comments and suggestions.

Best regards

Sincerely yours

Yi Dan.