December 28, 2013

Dear Editor,

Please find enclosed the edited manuscript in Word format (file name: ESPS-6457-edited.doc).

Title: Laparoscopic ligation of proximal splenic artery aneurysm with splenic function preservation

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Name of Journal: *World Journal of Gastroenterology*

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The manuscript has been improved according to the suggestions of reviewers:

1 Format has been updated

2 Revision has been made according to the suggestions of the reviewer

(1) **Reviewer1**: Dear Editor-in-Chief, Thank you for inviting me to review the paper: Laparoscopic ligation of proximal splenic artery aneurysm with preservation of splenic function: A Case Report. The authors presented their successful experience of laparoscopic ligation of asimptomatic proximal splenic artery aneurysm in 49-year-old woman. The paper is very well presented with very nice intraoperative figures. Literature is up-to date and in English literature there have been only two previous cases reported. I am suggesting to accepted the paper in presented form.

(2) **Reviewer2:** It is an interesting rare case report with nice laparoscopic views.

(3) **Reviewer3:** Wei et al. submitted a clinical case report of their successful treatment for proximal splenic artery aneurysm by laparoscopic clipping. As their suggestion, the procedure seems to be a promising alternative for the intra-abdominal aneurysm which is unsuitable or failed for IVR treatment. However, as the technique is sophisticated and severe complication (e.g. massive bleeding) may be concerned, I think IVR is still first treatment for aneurysm even in the reported site. The author should discuss the risk or limitation of the procedure. In addition, this article needs several minor revisions as follows. 1) Operation time and amount of bleeding should be described. 2) Were there any symptoms of pancreatic ischemia after the surgery? 3) The information of patient's ID and date of examination is distinguishable on the figures. They must be eliminated.

Answer: The risk of the laparoscopic ligation of SAA was the deficient residual blood flow to the spleen, thus leading to splenic infarction and possible evolution into splenic abscess. Therefore, the intraoperative ultrasound may contribute to recognition of the residual blood flow. (In the discuss section, paragraph4, highlighted in red).

The operative time was 50 min and blood loss was 10 mL. (In the case report section, paragraph3, highlighted in red).

On the postoperative follow-up, she recovered very well with no abdominal pain and pancreatic insufficiency. (In the case report section, paragraph3, highlighted in red).

According your advice, we eliminated the information of patient's ID and date of examination.

3 References and typesetting were corrected

Thank you again for publishing our manuscript in the *World Journal of Gastroenterology*.
Sincerely yours,

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