

Dear Editors and Reviewers:

Re:Manuscript ID: 78654 and Title: Successful resection of a huge retroperitoneal venous hemangioma: A case report and brief review of the literature.

Thank you for your precious comments and advice. 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 in red in the paper. The main corrections in the paper and the responds to the reviewer's comments are as flowing:

Response to the Editorial Office's comments:

Response to Science editor: We appreciate your suggestions and comments on our manuscript. We hence carefully revised the case presentation section and the following are the explanations for the comments: A 45-year-old female patient visited our hospital with the complaint of a retroperitoneal mass without symptoms discovered during a medical examination. CT revealed an enormous hypodense mass extending from the lower edge of the liver down to the right groin, with a regular margin and without marked enhancement in the arterial phase of the enhanced CT, which suggested a benign tumor. MRI revealed a retroperitoneal mass with low signal intensity on the T1-weighted image and high signal intensity on the T2-weighted image. So, our initial diagnosis is retroperitoneal benign tumor. A laparoscopic exploration and cystectomy were performed. During the laparoscopic surgery, we saw that the cyst was wrapped in fluid, so we broke the wall of the cyst and saw the milky white fluid. We also wondered why the milky fluid, could it be pseudocysts of the pancreas? So the fluid was immediately taken for laboratory testing, and the results indicated that amylase was not elevated. Finally, the mass was

completely resected and confirmed as a venous hemangioma by pathology.

Moreover, the mass protruded from the retroperitoneal space into the duodenal wall, and was firmly attached to the wall of the second part of the duodenum and the head of the pancreas. In order to protect the duodenum and pancreas, we switched to laparotomy surgery. About 2000 mL of milky white liquid was drained intraoperatively and the preoperative Ultrasonography revealed a large anechoic mass that occupied almost all of the right side of the peritoneal cavity, so we estimate the tumor size to be about 20cm. We couldn't get a complete picture of the tumor because the fluid flowed out after the cyst wall was broken. Figure 2 is to illustrate our complete separation of the cystic wall adhering to the duodenum.

Venous hemangioma is a benign and non-invasive type of tumor, regarding the postoperative follow-up time, the previous literature did not reach a clear conclusion. Therefore, we recommend attention should be paid to lesion residues after resection, and CT should be reviewed periodically during the follow-up period. It is because there is no gender or age difference in venous hemangioma and no specific clinical manifestations that the disease is rare.

Response to Company editor-in-chief: Our deepest gratitude goes to you for your careful work and thoughtful suggestions that have helped improve this paper substantially.

Response to the reviewer's comments:

Reviewer #1:

Response to comment: This case report is valuable because retroperitoneal venous hemangioma is rare, so diagnosis may be difficult without acknowledgement. Surgeons should excise this tumors en bloc without pre op aspiration or needle biopsy,

so this case report can be considered informative.

Response: Thank you for your summary. We really appreciate your efforts in reviewing our manuscript. We have revised the manuscript accordingly. We hope that the correction will meet with approval.

Reviewer #2:

Q1. Was a mass palpated?

Response: Yes. We felt no mass during our physical examination. We thought it might be a cystic mass that could not be clearly palpated.

Q2. The cyst was inadvertently ruptured intraoperatively?

Response: During the operation, we could see that the cyst was wrapped in fluid, so we broke the wall of the cyst and tried to separate the wall of the loose area first.

Q3. Were there 2 cysts? Or one bilocular cyst?

Response: Just one cyst. Instead of sequential resection of the cystic wall. We first removed the loose part of the cystic wall under laparoscopy, and then excised the cystic wall that was tightly adhered to the duodenum by laparotomy. So, the capsule wall is divided into two parts.

Q4. Why was a CT performed so early? What is your regular follow up after retroperitoneal benign lesion resection?

Response: Because we saw that part of the cyst wall was adherent to the duodenum intraoperatively, and that we lacked knowledge and experience with venous hemangioma disease, we reviewed the CT one month after surgery not only to see what remained of the mass, but also to observe the

recovery of the duodenum. We recommend CT review at 3 months, 6 months, and 1 year postoperatively.

Q5. Do you mean of the cyst? This would be a presenting symptom?

Response: This is a report from the literature in which the patient was normally asymptomatic until the mass in the retroperitoneum ruptured suddenly. The literature reported a spontaneous life-threatening hemorrhage of a retroperitoneal mass, subsequently pathologically confirmed to be a giant cavernous hemangioma.

Q6. It is known from other RP masses?

Response: We are not sure. Since the patient was asymptomatic and the mass was about 20cm, we hypothesized that the retroperitoneal space was large enough to allow the mass to grow slowly.

Q7. Was it a complete resection? Was there spillage of content? As possible risk factors for recurrence.

Response: This is a previous literature report. The authors reported " A 28-year-old man had a left lumbar cavernous hemangioma resected in another hospital. Two years later, he was admitted to the same hospital with recurrence of the left lumbar hemangioma. Abdominal computed tomography (CT) revealed a large retroperitoneal tumor with a papillary structure". The authors did not further discuss the details associated with the procedure and the risk factors for recurrence.

Q8. You mean that care should be taken to avoid spillage and partial

resection to prevent recurrence. And what would your follow up recommendations be? I suggest to make this paragraph as the final one.

Response: We consider that complete resection of the capsule wall may prevent recurrence, and we recommend periodic review of CT during the follow-up period. We will carefully revise these suggestions and write them in the last paragraph.

Q9. I suggest to rephrase it- imaging findings are not specific, but can aid to categorize the lesion as probably benign.

Response: There are many imaging findings are not specific, but can aid to categorize the lesion as probably benign.

Q10. And write a summary of the main features on each study from the literature and your case.

Response: We write a summary of the main features on each study from the literature in Table 2.

Q11. And the location and proximity to organs and structures?

Response: We have modified the sentence as "Therefore, it is recommended that preoperative imaging be used to assess both the benignity and malignancy of the tumor and the location and proximity to organs and structures surrounding tissue structures."

Q12. I would delete this sentence, since PRN usually are not correctly diagnosed preop. I would suggest that the final paragraph will be the one discussing recurrence, as aforementioned.

Response: We have deleted that sentence "In the present patient, the correct diagnosis was not made initially due to a lack of awareness of hemangioma."

Q13. I suggest to write instead that it can be resected in case it is large, symptomatic...

Response: We have modified this expression in conclusion according to the comment. CONCLUSION: Venous hemangioma is a rare disease benign lesion in adults, and an accurate diagnosis before surgery is challenging due to non-specific manifestations, imaging features and low incidence. Retroperitoneal venous Hemangiomas essentially involve no malignancy, but venous hemangiomas may grow and cause symptoms of compression as well as adhering to surrounding tissues. When symptomatic massive hemangiomas are present, surgery is considered. In addition, surgery is the curative treatment for venous hemangioma, and the definitive diagnosis relies on pathology. Attention should be paid to lesion residues after resection, and CT should be reviewed periodically during the follow-up period.

Q14. I suggest to add arrow to the lesion and duodenum.

Response: We have modified the figure according to the comment.

Reviewer #3:

Response: Thank you for your precious comments and advice. Those comments are all valuable and very helpful for revising and improving our paper. We have revised the manuscript accordingly, and our point-by-point responses are presented above.

Thank you again for your time and consideration. We hope that the revised manuscript is qualified for publication in *World Journal of Clinical Cases*.

Thank you very much for your work concerning my paper.

Yours respectfully,

Biao Wang