Reviewer 1

1. The specific date should be deleted from the text.

I have deleted the specific date from the text.

2. The reason for the 22-day non-surgical follow-up after diagnosis should be described.

After admission, the main symptoms of the 89-year-old patient were vomiting and he did not have obvious abdominal pain and abdominal examination showed slight abdominal tenderness in the epigastric abdomen without rebound tenderness. The patient had a history of gallstones for 10 years with intermittent right upper quadrant pain that was treated conservatively. On the one hand, gastrointestinal surgeon consultation determined that the patient had no indication for emergency surgery and recommended endoscopic therapy due to his age and high risk. On the other hand, the patient himself and his family members preferred relatively safe therapy. So at the beginning, we used gastrointestinal decompression and laser lithotripsy and found the effect was not poor. At last, the patient agreed to transfer to the the Department of Biliary-pancreatic Surgery, and undertook several preoperative examinations.

3. The reason why endoscopy was performed twice should be described in detail.

Mainly the patient himself and his family members were concerned about the risk of surgery and preferred relatively safe therapy and wanted to try again and detect the effect of the first therapy. So we performed the second endoscopy and found the effect was poor.

4. Was the patient's death due to surgical complications or bacteremia due to ileus?

Two days after the surgery, the patient presented with acute renal failure and tachycardia, high fever and myocardial damage. Six days after the surgery, the patient presented abdominal tenderness and rebound tenderness, exudate around the drainage tube, increase of drainage fluid and hypotension.

Doctors replaced the abdominal drainage tube and drainage fluid culture was positive for *Enterococcus faecium* twice. We used vasoactive agents and strong antibiotic treatment, the patient got better for several days and became worse again. Twenty-eight days after the surgery, abdominal CT showed slight exudation and effusion around the surgery region. Before surgery, the vital signs of the patient were stable. We assume the death was due to several surgical complications.

5. Was a nasal long tube inserted into the patient?

We just inserted nasal gastric tube into the patient.

6. The notation of figure in the text is difficult to understand. Shouldn't A, B, etc. be added to the notation?

Thank you for your advice. The figure legends are arranged by A, B. If figure A-D illustrated the same meaning, A-D were used.

7. Is fistula closure necessary for surgery in this patient? Considering her age, wouldn't jejunotomy and stone removal be sufficient?

According to references, due to her age and high surgery risk, enterolithotomy alone should be recommended.

Reviewer 2

1. Can you include laboratory findings related to the diagnosis? especially in acute diffuse peritonitis, septicemia, septic shock.

We have mentioned "Then, the patient presented with hyperpyrexia (39 °C) and disturbance of consciousness. Blood tests showed increase of white blood cell (10.11×10^9 cells/L, neutrophilic granulocyte percentage 90.5%). Procalcitonin was elevated at 31.01 ng/mL (normal range: < 0.05 ng/mL). High-sensitivity C-reactive protein was increased at 220.0 mg/L. Drainage fluid culture was positive for *Enterococcus faecium*." And the patient presented with hypotension and needed vasoactive agents to maintain blood pressure.

2. related to the cerebral infarction that occurs in the patient, is there any connection with the disease at the time of initial admission to the patient?

We did not perform cerebral CT scan at the time of initial admission. Twenty-three days after the surgery, the patient presented with lethargy and mouth breathing. Head CT showed low density in the left basal ganglia region and bilateral anterior horns of lateral ventricles indicating cerebral infarction.

The cerebral infarction was not massive cerebral infarction and was not related to clinical symptoms.

3. It is suggested that at the end of the discussion the cause of death of the patient may be added during treatment, to conclude its relationship to the case being discussed.

We have added this.