Reviewer #1: The authors report a case report of a 48-year-old man with successive ischemic malignant strokes in a patient with multiple fusiform aneurysms showing a devastating outcome despite conservative treatment. This case report is potentially interesting, but the manuscript can be improved according to the following minor suggestions:

1Please add in the title “ischemic” (“ischemic malignant strokes”).

Response)

I modified the title following your comment.

Successive development of malignant strokes in a patient with multiple fusiform aneurysms: A case report

→ Successive development of ischemic malignant strokes in a patient with multiple fusiform aneurysms: A case report

2.It should be noted in the Introduction, that in a hospital clinical series, decreased level of consciousness, nausea or vomiting, and heavy smoking were the main clinical factors associated with malignant middle cerebral artery infarction (Rev Invest Clin 2015: 67: 64-70). We recommend including and commenting on this reference.

Response)

I carefully read the reference you recommended. The point of this reference is that smoking, decreased consciousness, nausea and vomiting are the main clinical data of the malignant MCA infarction. However, our case report focuses on fusiform aneurysm and dissection. I am not sure if I should mention that reference in this case report. I ask for your kind advice.

3.It would be helpful to mention that the differential diagnosis of the presented case also refers to hematological disorders. It would be interesting to mention that hematological disorders are another commonly unrecognized cause of both acute stroke of unusual etiology and malignant ischemic stroke (Expert Rev Hematol 2016; 9: 891-901). The inclusion and comment on this reference is recommended.

Did the authors consider this in their study protocol?

Response)

Yes, we considered that in our study protocol.

I added the following sentence (Page 5 line 4)

Subsequent tests revealed elevated IgM anticardiolipin antibody (29.0 CU; normal range ≤ 20) and IgM anti-beta-2 glycoprotein I (23.5 CU; normal range < 20), and decreased antithrombin III (51%; normal range 75–125) and protein C (63%**;** normal range 73–142).

I revised the sentence as below (Page 5, line 7)

The results of following investigations were unremarkable: transthoracic echocardiography, Holter monitoring, glycated hemoglobin, low-density lipoprotein and alpha-1 antitrypsin.

→ The following investigations were unremarkable: transthoracic echocardiography, Holter monitoring, glycated hemoglobin, low-density lipoprotein, alpha-1 antitrypsin, protein S, and lupus anticoagulant.

I added the following sentences in the Discussion, including the reference you recommended (Page 6, line 23).

Hematological disorders are another commonly unrecognized cause of both acute stroke of unusual etiology and malignant ischemic stroke (I quoted the reference you recommended). Iseki et al. reported cases of cerebral artery dissection secondary to antiphospholipid syndrome and suggested that the interaction between antiphospholipid antibodies and endothelial cells may contribute to dissection development. Persistently elevated titers of antiphospholipid antibodies, including anticardiolipin and anti-beta-2 glycoprotein I, at least 12 weeks apart, are essential for the diagnosis of antiphospholipid syndrome; however, follow-up examinations were not available for our patient.

4.t would be interesting if the authors included in the text some of the limitations of this case note.

Response)

I added the following sentence at the end of the Discussion paragraph.

This case report had several limitations. First, a digital subtraction angiography was not performed. Second, the mechanisms of dissection, such as connective tissue disease, have not been sufficiently evaluated.

5.A brief concluding comment on possible lines of future research on the topic presented would be appreciated.

Response)

I added the following sentence at the end of the Conclusion paragraph.

Future studies on treatment strategies based on the pathophysiology and risk profiles of multiple fusiform aneurysms are needed.

Thank you very much for your valuable comments.