

Dear Editors and Reviewers:

Thank you for your letter and for the reviewers' comments concerning our manuscript entitled "Recurrent biliary hemorrhage caused by metastasis of a malignant small round cell tumor in the common bile duct: a case report" (Submission Manuscript ID : 88005). 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 highlighted with yellow color in the revised manuscript. The main correction in the paper and the responds to the reviewer's comments are as follows:

Reviewer 1

1. **Comment 1:** Authors have done a good job highlighting a rare case of haemobilia. Although there are no significant case reports on metastatic small round cell tumors presenting as haemobilia and bile duct metastasis, the paper has several grammatical and language errors. The authors need to update the manuscript with accurate information and also check the manuscript for grammatical and language errors and then consider resubmitting for review.

Reply 1: According to the reviewer's suggestion, we have polished this manuscript through a professional English language editing company (American Journal Experts) recommended by our magazine to ensure that all grammar, syntax, formatting, and other related errors are resolved, so that the revised manuscript meets the publishing requirements.

2. **Comment 2 :** Also while describing the case the authors mention that the cholangiocarcinoma was removed, which appears to be a confusing statement since the case report is discussing SRCTs and not cholangiocarcinoma.

Reply 2: This case report discusses SRCTs. Due to confusion between SRCTs and generalized cholangiocarcinoma, I mistakenly described SRCTs as cholangiocarcinoma in this manuscript. I have corrected the relevant description of

cholangiocarcinoma to SRCTs.

3. Comment 3: The use of spyglass and stent for bleeding management does not correspond with a newer advancement as these testing and treatment modalities have been used for quite some time in the diagnosis and management of biliary lesions.

Reply 3: Thank you for your comment. Indeed, spyglass and the use of biliary stents for hemostasis have been widely applied in clinical practice in the diagnosis and treatment of biliary bleeding. However, the definitive diagnosis, obtaining pathological tissue, and successful biliary hemostasis in this case report are inseparable from the application of the aforementioned techniques. Thank you again for your suggestion.

Special thanks to you for your good comments !

Reviewer 2

1. Comment 1: We could offer our congratulations to the authors for presenting this unusual clinical case, along with their diagnosis and management approach. It is indeed a rare clinical case; however, it remains unfortunately incomplete due to the lack of follow-up information post-surgery.

Reply 1: According to the reviewer's suggestion, we have added relevant follow-up information for patients after surgery. After excision of the common bile duct tumor, the patient felt that the abdominal pain had improved, and the hemorrhage had disappeared. The patient underwent routine fecal examination one month after surgery, and the fecal occult blood test was negative. On May 22nd, 2023, the patient was reexamined with abdominal CT, and no abdominal space-occupying lesions or abdominal lymphadenopathy were found.

2. Comment 2: The authors should consider adding details regarding the efficacy of endoscopic treatment with a covered biliary stent in controlling the hemobilia. While they report pain and hemorrhage control after surgery, further clarification on this

aspect would be beneficial.

Reply 2 : Thank you for your suggestion. We have added the specific operation process to the revised manuscript. Details are as follows: The gastroscopy showed that the gastroduodenal mucosa was smooth and pale. The main nipple was found to be changed after EST without blood stains. The nipple was incised with a knife, and dark red liquid was discharged (Fig. 1A). On duodenoscopy, the scope was successfully passed through the esophagus, stomach and duodenal bulb, and reached the descending part, and the main nipple was found and was intubated successfully. The amount of contrast agent used was 20 ml. X-ray showed that the common bile duct had developed without expansion, and the maximum diameter was approximately 0.8 cm. It was filled with filling defects of different sizes. The intrahepatic bile duct was partially developed without expansion. There were irregular filling defects in the middle and lower segments of the common bile duct, which could be moved. The bright red liquid was discharged. The cystic pancreatic duct was not developed. The biliary tract was cleared through the zebra guide wire airy catheter, and the bleeding clots and necrotic tissues were removed. After insertion of the spyglass and after repeated flushing, new organisms could be seen in the middle of the common bile duct, with a rough surface, necrosis of the surface, active bleeding and local lumen stenosis (Fig. 2C). Spy-Bite was performed. Then, the storage guide wire was inserted into the biliary full posterior membrane metal stent (Fig. 1B). After release, the stent was in a good position.

3. Comment 3 : The type of surgery performed is not clearly specified. In the context of distal malignant biliary tumors, the Whipple procedure is typically the standard surgical approach. The authors mentioned, "Cholangiocarcinoma resection and loosening of intestinal conglutination were performed." It would be greatly appreciated if the authors could provide a more detailed and comprehensive explanation of the procedures undertaken.

Reply 3: According to the reviewer' s suggestion, we added the following contents: The operation method of this patient was "Roux-en-Y cholangiojejunostomy". The

specific operation is as follows: first, the abdominal cavity was opened, the middle and upper segment of the common bile duct were expanded, with a diameter of approximately 1.3 cm, there was a palpable mass in the common bile duct approximately 2 cm below the confluence of the left and right hepatic ducts, there was a medium texture and no enlarged lymph nodes were found around it. Then, the bile duct was cut, and a circular yellow and white cauliflower-like new organism was found in the common bile duct, with approximately 2/3 circles around the common bile duct. The bile duct lesions were removed. On the premise of clear distal patency of the common bile duct, the common bile duct was transected to prepare for the establishment of a new biliary intestinal channel. The distal end of the common bile duct was closed, and the proximal end of the common bile duct was temporarily clamped with nondestructive forceps to prevent bile from flowing into the abdominal cavity. Then, the upper segment of the jejunum was cut off, the transverse colon was lifted down along its mesangium, and the duodenal jejunal flexure was found. The first jejunal artery was kept on the jejunal mesentery, the second jejunal artery was cut off, the jejunal mesentery was separated, cut and ligated so that the distal jejunum had enough freedom, and there was no tension after the abovementioned choledochojejunostomy. The free distal jejunum was sutured and closed and then lifted to the porta hepatis through the colon for anastomosis. The distal jejunum was lifted 60 cm and anastomosed with the proximal jejunum side to side. A small opening on the side of the opposite edge of the mesentery with the sutured stump was made into the distal jejunum lifted from the transverse mesocolon fissure. The direction was parallel to the long axis of the intestinal tube, the size corresponded to the repaired bile duct orifice and the incision was anastomosed with the jejunum. Finally, the abdominal cavity was closed after the drainage tube was placed.

Reply 4 : First of all, thank you for your comments and opinions. We added the following content to the revised manuscript: the patient underwent tumor resection on the left shoulder, back and left supraclavicle 9 years ago. No chemotherapy was taken after operation. Unfortunately, the excision of the MSRCT on the back of the patient was performed in another hospital in Hangzhou. The specific surgical procedure is

unknown. At present, the patient has no obvious symptoms, so the patient and his family members are not willing to travel long distances to Hangzhou again in order to borrow the surgical and pathological sections 9 years ago, which is not very convenient for them. Therefore, we cannot present the pathological picture of the operation of MSRCT in the left shoulder, back and left supraclavicle 9 years ago in this manuscript. Thanks again for the experts' suggestions, which will be taken seriously in the future.

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 your warm work earnestly, and hope that the corrections will meet with approval.

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

Thank you and best regards.

Yours sincerely,

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