

(1) Science editor:

The authors report a complex repair of thoracoabdominal aortic aneurysm. Respected authors, this is a well written paper and covers an interesting topic. The choice of the references is outdated: only few refs are younger than 10 years! The author's discussion section can explain whether there are other treatments for a wide range of CAAA and the causes of adverse reactions related to the disease.

Response: Thank you for your comments. We have included treatment options for visceral vessel repair and its predictors for mortality in the discussions section. We also updated our references to the more recent ones.

(2) Company editor-in-chief:

I have reviewed the Peer-Review Report, the full text of the manuscript, and the relevant ethics documents, all of which have met the basic publishing requirements of the World Journal of Clinical Cases, and the manuscript is conditionally accepted. I have sent the manuscript to the author(s) for its revision according to the Peer-Review Report, Editorial Office's comments and the Criteria for Manuscript Revision by Authors. The title of the manuscript is too long and must be shortened to meet the requirement of the journal (Title: The title should be no more than 18 words). Before final acceptance, the author(s) must provide the English Language Certificate issued by a professional English language editing company. Please visit the following website for the professional English language editing companies we recommend: <https://www.wjgnet.com/bpg/gerinfo/240>. Please provide the original figure documents. Please prepare and arrange the figures using PowerPoint to ensure that all graphs or arrows or text portions can be reprocessed by the editor.

Response: Thank you for your comments. We shortened our title to 18 words. We are now also including English Language Certificate issued by AJE. We also attached the original PowerPoint file for the sake of additional editing.

Reviewer #1

1.The aneurysm reported in this manuscript should be a Crawford type IV thoracoabdominal aortic aneurysm.

Response: Thank you for your comment. We have further revised our manuscript to your advice.

2. The patient had high risk for open surgery because he had a history of heavy smoking and chronic total occlusion of the mid right coronary artery without a percutaneous coronary intervention. At present, the total endovascular technique using custom-made branched endograft or physician modified branched endograft has been used for this kind of thoracoabdominal aortic aneurysm successfully.

Response: The main reason why we pursued non-invasiveness was because the patient had poor performance. He has complained that his ECOG performance status was 2 (unable to carry out any work activities) ever since he had renal tuberculosis. Also, his previous medical records showed fluctuating creatinine levels.

3.Why another bifurcated graft wasn't been used to anastomosis to bilateral external iliac artery directly, now that open surgery has been performed to reconstruct the thoracoabdominal aorta, visceral branches and renal arteries. The procedure won't increase too much technical difficulty, injury and cost.

Response: The patient's performance status was poor even before surgery, as he his ECOG performance status was 2 after he suffered from renal tuberculosis. Previous literature show that poor performance status may be an independent predictor of mortality in patient undergoing visceral vessel repair (PMID: 21723071). We, therefore, thought that pursuing non-invasiveness would be best suited for the patient.

After the first surgery, where we inserted the branched graft, the patient stayed in the intensive care unit (ICU) for approximately 50 days due to acute hepatic and renal injury. The patient strongly refused of undergoing any type of additional intervention, including surgery due to the

traumatic memories of staying in the ICU and this was why we had to delay the second stage EVAR for 15 months. We further elaborated this notion in the case presentation and discussions section.

Reviewer #2:

Specific Comments to Authors: Name of Journal: World Journal of Clinical Cases Manuscript NO: 73004 Manuscript Type: CASE REPORT Comments: Complex abdominal aortic aneurysm (CAAA) is required aggressive surgery and associated with a higher perioperative mortality. The author reported a case where brached graft was implanted covering half of the aortic disease, which was followed by a stent graft inserted through endovascular aortic repair to minimize aggressive surgery in a patient with extensive CAAA. The subject of this manuscript is of value, but there are a few of defects need to be modified.

1.CASE SUMMARY section: A 60-year-old male presented with a Crawford type IV CAAA starting directly dista.....Please change CAAA to: complex abdominal aortic aneurysm (CAAA).

Response: Thank you for pointing out the error. We have revised the text to your comments.

2.Should the author discuss the causes, prevention and treatment of renal and liver injury after surgery in more detail.

Response: Thank you for your comments. We added the complication rate of visceral vessel repair (VVR) and the independent predictors leading to death after VVR (PMID: 21723071). Poor performance status before surgery was one of the few ominous predictors for mortality (PMID: 21723071), which can relate to the current case. We also added several surgical methods to prevent liver or renal injury caused by VVR (PMID: 25720924 and PMID: 29590367). Selective renal perfusion and selective visceral perfusion are some ways for preventing ischemic injury, although reducing ischemic time may be the most crucial method (PMID: 29552513).

Round 2

Response to Reviewer

Comment 1. Please optimize your terms and clinical definitions. For instance, what is your computerized tomographic angiography means? This is very old-fashioned English. There is a computed tomography angiography only! Please elaborate on it.

Response to reviewer: Thank you for pointing out the error. We have modified to computed tomography in the manuscript.

Comment 2. Imaging: Please explain how many experts and surgeons were involved exactly. Is that an expert-level analysis? Any validated software was involved?

Response to reviewer: Three interventional cardiologists, one experienced cardiothoracic surgeon, and one vascular surgeon were involved in the process.

Comment 3. Imaging: your images must be comprehensively (from the technique point of view) and critically (any technological flaws, a success - technically and clinically) described.

Response to reviewer: We have added this information to the manuscript in the imaging section.

Comment 4. If you mention that there were damage of liver of kidney, it must be clear what kind of damage?! I am talking about any clinical parameters, results of biochemical analysis, even ECG, any markers of myocardial damage, D-dimer, heart failure. How "poor" was general clinical condition of the patient?

Response to reviewer: The liver and kidney failure after the surgery is thoroughly discussed in the discussion section with a longitudinal diagram of both the liver and kidney functions. The creatinine and total bilirubin is shown in Figure 2.