



Reviewer's code: 06215370

<b>Scientific quality</b>	<input type="checkbox"/> Grade A: Excellent <input type="checkbox"/> Grade B: Very good <input type="checkbox"/> Grade C: Good <input checked="" type="checkbox"/> Grade D: Fair <input type="checkbox"/> Grade E: Do not publish
<b>Language quality</b>	<input type="checkbox"/> Grade A: Priority publishing <input type="checkbox"/> Grade B: Minor language polishing <input checked="" type="checkbox"/> Grade C: A great deal of language polishing <input type="checkbox"/> Grade D: Rejection
<b>Conclusion</b>	<input type="checkbox"/> Accept (High priority) <input type="checkbox"/> Accept (General priority) <input type="checkbox"/> Minor revision <input checked="" type="checkbox"/> Major revision <input type="checkbox"/> Rejection
<b>Re-review</b>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

#### SPECIFIC COMMENTS TO AUTHORS

Comments: Thanks for sharing such an interesting case, but I have some questions: 1. The authors mentioned that "the mass was also adhered to the pancreas," and there are several reports that peri-pancreatic lymphangioma was "diagnosed by endoscopic ultrasound (EUS)-fine-needle aspiration (FNA) cytology" (such as DOI: 10.17235/reed.2020.7671/2020). Thus it is necessary to clarify whether the EUS procedure was done before excision (it would help determine whether the enlarged cyst was benign or malignant) and why not. 2. The author also mentioned that "aspiration revealed a light-yellowish turbid fluid." Did the patient have a suspicious history of pancreatitis, and was there any test result suggesting infection when the cyst enlarged? After Laparotomy, was the cyst fluid tested for amylase and lipase? 3. Advances in EUS-guided diagnostics (including cyst fluid molecular analysis, EUS-guided needle-based confocal laser endomicroscopy, and EUS-guided needle microforceps biopsy) have increased the accuracy of differentiating peri-pancreatic cystic lesions. It is suggested to supplement the differential diagnoses of lymphangioma in the discussion section. 4. There are still some spelling and article usage issues in this manuscript that need to be carefully checked and revised, such as in "The postoperative period was uneventful except for paralytic ileus,



**Baishideng  
Publishing  
Group**

7041 Koll Center Parkway, Suite  
160, Pleasanton, CA 94566, USA  
**Telephone:** +1-925-399-1568  
**E-mail:** bpgoffice@wjgnet.com  
**https://**www.wjgnet.com

and the patient was discharged on post-operative day (POD) 15 with satisfactory relief from previous symptoms."

**Response:**

1. The authors mentioned that "the mass was also adhered to the pancreas," and there are several reports that peri-pancreatic lymphangioma was "diagnosed by endoscopic ultrasound (EUS)-fine-needle aspiration (FNA) cytology" (such as DOI: 10.17235/reed.2020.7671/2020). Thus it is necessary to clarify whether the EUS procedure was done before excision (it would help determine whether the enlarged cyst was benign or malignant) and why not.

Thank you for your comments and for pointing out the importance of differentiating peri-pancreatic cystic lesions. We appreciate your emphasis on approaching peri-pancreatic cysts with possible EUS diagnosis and fluid aspiration analysis. Regarding the above comments:

EUS and EUS-FNA were not performed for mainly three reasons. Firstly, the initial CT finding (7 years ago) clearly demonstrated the cyst did not originate from the pancreas (We changed a figure (figure 1A) to show the origin of cystic mass). Secondly, pre-operative CT showed collapse of the stomach and duodenum due to the huge mass (Also figure 1B has been changed to show above finding); furthermore, the pancreas was in between the duodenum and cyst, leaving no window for an endoscopic procedure. Above all, the goal of the surgery was not only ruling out malignancy but promptly relieving the patient's symptoms due to mass effect. Hence, even if differential diagnosis via EUS had been possible, the patient ultimately required surgical treatment.

We have read the article you referenced (DOI: 10.17235/reed.2020.7671/2020) and acknowledge that in certain cases EUS FNA cytology may be an appropriate method of diagnosis. However, this report is focused on diagnosis itself and makes no mention of symptom relief and, hence, the need for surgical treatment. Also, the authors mention two



**Baishideng  
Publishing  
Group**

7041 Koll Center Parkway, Suite  
160, Pleasanton, CA 94566, USA  
**Telephone:** +1-925-399-1568  
**E-mail:** bpgoffice@wjgnet.com  
**https://**www.wjgnet.com

relatively small cysts –one adjacent to the pancreatic tail, and another located between the duodenum and liver –but did not specify which one EUS-guided fluid was aspirated from. Assuming it was from the cyst near the duodenum, this would differ from our case which was a left-sided retroperitoneal mass (and did not originate from the pancreas as confirmed by initial CT findings).

2. The author also mentioned that "aspiration revealed a light-yellowish turbid fluid." Did the patient have a suspicious history of pancreatitis, and was there any test result suggesting infection when the cyst enlarged? After Laparotomy, was the cyst fluid tested for amylase and lipase?

: The patient did not have symptoms suggesting pancreatitis such as severe, sudden epigastric pain or radiating pain to the back. Serum amylase and lipase levels were within normal limits, and the patient denied risk factors such as alcohol consumption, smoking, or previous history of pancreatitis. Also, the patient presented with no signs of infection such as fever or leukocytosis. We revise our description of the cystic fluid from "light-yellowish turbid" to "serous with yellow patches", and appreciate your remarks on our inappropriate description. Hence, we believe the adhesions of the medial and superior border of the mass to the pancreas were most likely a result of inflammation because of chronic external compression, and not pancreatitis.

3. Advances in EUS-guided diagnostics (including cyst fluid molecular analysis, EUS-guided needle-based confocal laser endomicroscopy, and EUS-guided needle microforceps biopsy) have increased the accuracy of differentiating peri-pancreatic cystic lesions. It is suggested to supplement the differential diagnoses of lymphangioma in the discussion section.

: As per our reply to point '1.', the main goal with our case patient was adequate relief of symptoms (whilst also confirming diagnosis), rather than focusing on a specific diagnosis itself.



4. There are still some spelling and article usage issues in this manuscript that need to be carefully checked and revised, such as in "The postoperative period was uneventful except for paralytic ileus, and the patient was discharged on post-operative day (POD) 15 with satisfactory relief from previous symptoms.

: Thank you for your comment. We have re-checked and revised the article for such issues.

**Reviewer's code:** 05190615

<b>Scientific quality</b>	<input type="checkbox"/> Grade A: Excellent <input type="checkbox"/> Grade B: Very good <input checked="" type="checkbox"/> Grade C: Good <input type="checkbox"/> Grade D: Fair <input type="checkbox"/> Grade E: Do not publish
<b>Language quality</b>	<input type="checkbox"/> Grade A: Priority publishing <input checked="" type="checkbox"/> Grade B: Minor language polishing <input type="checkbox"/> Grade C: A great deal of language polishing <input type="checkbox"/> Grade D: Rejection
<b>Conclusion</b>	<input type="checkbox"/> Accept (High priority) <input checked="" type="checkbox"/> Accept (General priority) <input type="checkbox"/> Minor revision <input type="checkbox"/> Major revision <input type="checkbox"/> Rejection

**SPECIFIC COMMENTS TO AUTHORS**

Lymphangiomas are benign tumors commonly found in children, adult cases are extremely rare, especially for the huge mass. Because the tumor is cystic space occupying it is not difficult to resect the tumor. However surgical decompression will alleviate the symptoms of compression in patients. Therefore it is suggested to point out in the conclusion that the tumor is benign and grows slowly so it can be continued to be observed before compression symptoms appear.

**Response:** Thank you for your suggestion. We have revised the conclusion as commented.



Reviewer's code: 06215370

<b>Scientific quality</b>	<input type="checkbox"/> Grade A: Excellent <input type="checkbox"/> Grade B: Very good <input checked="" type="checkbox"/> Grade C: Good <input type="checkbox"/> Grade D: Fair <input type="checkbox"/> Grade E: Do not publish
<b>Language quality</b>	<input type="checkbox"/> Grade A: Priority publishing <input checked="" type="checkbox"/> Grade B: Minor language polishing <input type="checkbox"/> Grade C: A great deal of language polishing <input type="checkbox"/> Grade D: Rejection
<b>Conclusion</b>	<input type="checkbox"/> Accept (High priority) <input checked="" type="checkbox"/> Accept (General priority) <input type="checkbox"/> Minor revision <input type="checkbox"/> Major revision <input type="checkbox"/> Rejection

#### SPECIFIC COMMENTS TO AUTHORS

Thanks to the authors for their answers, although I have different opinions on the 1st and 3rd questions.

**Response:** Thank you very much for your 2<sup>nd</sup> review.

Along your recommendation, I made my revised manuscript re-edited and sent.

Again, I thank you for your time for review.