

Reviewer 1

Interesting case, well presented.

Response: Thank you very much for your comments.

Reviewer 2

An interesting paper about a pseudoaneurysm between duodenum and pancreas after an episode of acute cholecystitis treated with cholecystostomy. It emphasizes the importance of being aware of pseudoaneurysms as a possible cause of gastrointestinal bleedings. Can the authors explain how the pseudoaneurysm developed despite the absence of an inflammatory process in the close vicinity of pancreas or duodenum? I do not understand how an acute cholecystitis (at least if it was not associated with pronounced local inflammation) or the cholecystostomy could affect the pancreaticoduodenal artery. Could there have been a concomitant acute pancreatitis, or an episode of pancreatitis in the interval between the episode of acute cholecystitis and second admission?

Response: PDA pseudoaneurysms can occur after pancreatitis, abdominal trauma, septic emboli, iatrogenic injuries, penetrating duodenal ulcers, and malignancies, and they often rupture into the gastrointestinal tract(1, 2). The pseudoaneurysms of cystic artery and hepatic artery secondary to cholecystitis or percutaneous intervention of biliary tract have been reported(3, 4). However, no researches have showed the relationship between calculous cholecystitis or interventional procedures of the biliary tract and PDA pseudoaneurysms.

We detected amylase of the patient in his first and second admission. The results were normal in both times. Furthermore, the CT scans never revealed the sign of acute pancreatitis. Whether the patient suffered acute pancreatitis in the interval between the episode of acute cholecystitis and second admission was unknown. The patient was admitted to hospital due to severe acute cholecystitis in poor clinical condition. The white cell count (WBC) was $28.80 \times 10^9/L$, neutrophil ratio (NE%) was 91.99%, and C-Reactive Protein (CRP) was 217.00mg/L. These results revealed a serious infection. As septic emboli is a precipitating factor of PDA pseudoaneurysms. I think septic emboli may caused the emerging PDA pseudoaneurysm in this patient. It is my humble opinion. Thank you.

Reference:

1. al-Jeroudi, A., A. M. Belli, and P. J. Shorvon. 2001. False aneurysm of the pancreaticoduodenal artery complicating therapeutic endoscopic retrograde cholangiopancreatography. *The British journal of radiology* 74: 375-377.
2. Pasha, S. F., P. Gloviczki, A. W. Stanson, and P. S. Kamath. 2007. Splanchnic artery aneurysms. *Mayo Clinic proceedings* 82: 472-479.
3. Tapnio, R. H., M. K. Kolber, P. A. Shukla, and E. Berkowitz. 2017. Transcatheter Embolization of Cystic Artery Pseudoaneurysms Secondary to Acute Cholecystitis. *Vascular and endovascular surgery* 51: 498-500.
4. Hangai, S., A. Ohata, M. Kageoka, M. Mori, T. Shimura, H. Uozaki, T. Shimamura, F. Watanabe, and Y. Maruyama. 2014. Successful transarterial embolization for recurrent pseudoaneurysm of the right hepatic artery with acute cholecystitis. *Clinical journal of gastroenterology* 7: 164-169.