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Dear Editor,

Thank you for your positive decision and reviewers' comments. We are re-submitting the enclosed manuscript entitled "**Portal hypertension in a case with biliary hamartomas**" for your consideration for publication as a "**Case report**" in the **World Journal of Clinical Cases**. My colleagues and I have revised the manuscript according to your comments. The revised paper has been uploaded. A point to point response has been attached below.

In this work, we guarantee that the contents described in this case report are completely accurate, and the manuscript is an original work that has not been published nor is under consideration for publication elsewhere. All of the authors made an intellectual contribution to the manuscript and approved this submission. We have no conflict of interest.

Thank you for your consideration.

Sincerely yours,

Dr. Xingshun Qi, MD
Department of Gastroenterology,
General Hospital of Northern Theater Command (formerly called General Hospital of Shenyang Military Area),
No. 83 Wenhua Road, Shenyang, China.
Tel: 86-24-28897603;
Fax: 86-24-28851113;
Email: xingshunqi@126.com

Response to the Reviewers' Comments

Reviewer 1

Report of a 40 years old patient presenting with signs of portal hypertension, gastroesophageal vatical bleeding and multiple irregular, round lesions in the liver. Although not definitely proven, the authors present their observations as a rare case of complicated biliary hamartoma, type Von Meyenburg complexes.

Question 1. The diagnosis is incomplete, no liver biopsy was made, thus neither the lesions nor the "regular" liver tissue was investigated histologically. Therefore the case report in its core message is only speculative.

Reply: Thank you very much for your comments.

The accurate diagnostic method for BH is liver biopsy. However, the patient refused the biopsy, so we have performed multiple imaging tests. We have explained this limitation in the **Discussion** section.

Question 2. The CASE SUMMARY describes the case presenting with hematochezia. Hematochezia means fresh, red, bloody stools, which is not typical for gastroesophageal bleeding sources. Maybe the authors use melena and hematochezia synonymously, which is not correct.

Reply: Thank you very much for your comments. We agree with your considerations.

The endoscopic examination has confirmed that the patient's source of gastrointestinal bleeding should be gastroesophageal varices, but the volume of gastrointestinal bleeding should be so large that he presented with dark red colored bloody stool, except for melena. According to your comments, we have corrected the sentences in the **Case presentation** section, which are highlighted by yellow, as follows:

On September 20, 2018, a 40-year-old man presented with dark red colored bloody stool for one day.

Question 3. The CASE PRESENTATION describes twice observations of September 20, 2018 but it is not clear, whether the second gastroscopy was a follow-up after the initial intervention on the same day. If so, the time interval and indication should be given.

Reply: Thank you very much for your comments. We agree with your considerations.

We checked the medical records and confirmed that the date when upper gastrointestinal endoscopy was performed should be September 21, 2018. We have corrected the sentences in the **Case presentation** section, which are highlighted by yellow, as follows:

On September 21, 2018, the patient underwent upper gastrointestinal endoscopy, showing mild esophageal varices, portal hypertensive gastropathy, and a removing tissue glue at the gastric fund which was considered as the major source of gastrointestinal bleeding.

Question 4. More disturbing is the wording "Thus, our endoscopist did not undergo endoscopic variceal therapy. Meant is probably that the endoscopist did not perform an endoscopic therapy on the patient (and not on himself).

Reply: Thank you very much for your comments. We agree with your considerations.

We have corrected the sentences in the **Case presentation** section, which are highlighted by yellow, as follows:

Thus, our endoscopist did not perform endoscopic variceal therapy on this patient.

Question 5. The DISCUSSION explains why the liver could not be biopsied, but the reference list is not up to date. The most recent reference dates from 2015, although several papers have been published on this topic more recently, for instance "Magnetic resonance imaging of fibropolycystic liver disease: the spectrum of ductal plate malformations. Abdom Radiol (NY), 2019 Jun; 44(6):2156-2171."

Reply: Thank you very much for your comments. We agree with your considerations.

We have read this paper and updated the reference list.

Reviewer 2

Multicystic biliary hamartoma (von Meyenburg complexis) a rare liver lesion that has been described as a distinct entity from other previously classified hepatobiliary cystic lesions. Symptomatic cases are rare, and esophageal varices typically are not noted. I know of only 1 case identifiedin the English medical literature (S. Yoshida et al. DOI: 10.1111/j.1478-3231.2008.01903.x). In the case submitted for review, the authors described the classic imaging features of von Meyenburg complex detected by computed tomography, magnetic resonance imaging and magnetic resonance cholangiopancreatography. However, the lack of histological verification of the diagnosis significantly reduces its quality. Firstly, it is generally thought that the persistence of immature duct elements stimulates the formation of portal fibrous tissue. Therefore, if fibrosis by von Meyenburg complex occurs in all or extensive portal vein area it might contribute to portal hypertension. In addition, multicystic biliary hamartoma should be carefully differentiated from a variety of other neoplastic and non-neoplastic hepatobiliary cystic lesions.

Reply: Thank you very much for your comments.

We have referred to the case by Yoshida et al., which considered that BH was a rare potential etiology of portal hypertension. Yoshida et al. mainly believed that the formation of portal hypertension was associated with the compression of BH. In our case, we considered that portal hypertension might be also associated with the presence of fibrosis in patients with BH.

We have expanded the differential diagnosis in the **Discussion** section, which are highlighted by yellow, as follows:

Fifth, abscesses are inflammatory lesions characterized as double target sign on CT which consist of hypodense pus area, hyperdense ring of granulation tissue, and hypodense zone of inflammatory edema[21]. Besides, abscesses could be readily differentiated from BH by clinical symptoms, such as fever and abdominal pain[22].