

Dear editor, thank you for your suggestion and comments on this paper. I'd like to take your advice to transfer this manuscript to the World Journal of Clinical Cases and revise according to the current reviewers' comments. The manuscripts have been revised as follows:

**Comment 1: Major points:** How could the authors diagnose this tumor as pancreatic origin. Authors should describe the pathological findings differentiating pancreatic origin from head and neck origin.

Reply : We discussed as follows and add the content to the discussion part.(change in the manuscript: see Page 6, line 7-24):

The ACC characteristic microscopic architecture patterns are the acinar units, with neoplastic cells arranged in small acinar units, and solid patterns, with solid nests of neoplastic cells lacking luminal formations. In our case, the tumor combines the characteristic acinar growth pattern and neuroendocrine marker-negativity and acinar structures which tumor cells distributed in present the same as pancreatic acini. No lesion was detected either by imaging instruments (CT, MRI, EUS) or during the surgical exploration and the confirmation of the macroscopic intrapancreatic tumor was absent. Besides, we also have taken into account the differentiation of salivary gland acinar cell carcinoma which mostly occurs in the parotid gland and its histological characteristics present serous acinar differentiation, with frequent expression of CK and partial expression of S-100. Since there was not any identified workup of a primary salivary gland tumor from head or neck and the histological and immunohistochemical studies did not support the origin of head or neck, the origin of our case was not considered from head or neck. As the exclusion of a pancreatic or head and neck origin could be proved, and the presence of associated glandular components had been revealed, we speculated our ACC case originated from retroperitoneal multipotential progenitor cell that acquires acinar pancreatic features, and we diagnosed a pancreatic-type ACC of the right perinephric space.

**Comment 2: Minor points:**

Reply 1: Fiuger 1. We measured the CT value of the enhancement of the tomor, in arterial phase the CT value of the tumor was 111 HU, in portal vein phase the CT value of the tumor was 95 HU, in delayed phase the CT value of the tumor was 79 HU, showing lower in Fig. 1D than in Fig. 1C. (change in the manuscript: see Page 16, line 5-6).

Reply 2: Legend of the Figure 2: we changed the expression of "a hypointense mass" to the expression of "hyperintense signal on fat suppression T2WI (A) and hypointense signal on T1WI (B)". (change in the manuscript: see Page 17, line 2-3).

Reply 3: Legend of the Figure 3: we changed the "forchromogranin" to "for chromogranin". (change in the manuscript: see Page 18, line 3).