Format for ANSWERING REVIEWERS

August 26, 2014

Dear Editor,

Please find enclosed the edited manuscript in Word format (file name: 12046-edited.doc).

Title: Endoscopic variceal ligation caused massive bleeding due to laceration of an esophageal varicose vein with tissue glue emboli

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The manuscript has been improved according to the suggestions of reviewers:

1 Format has been updated.

2 Revision has been made according to the suggestions of the reviewer

(1) In the discussion, the authors introduced two methods of recognizing the dangerous esophageal varices containing the glue plug in theory. However, those methods were not routinely or conveniently applied in clinical practice. Are there any other approaches to identifying such special varices? More papers should be reviewed: Yes, as we have described in this paper, usually, when we perform EVL in a patient with a history of tissue glue injection for gastric varices, we will compress the esophageal varicose vein gently using the transparent cap to see whether it is hard or not, the ligation site is at least 5mm to 10mm proximal to the Z-line and the suction should be slowly and gently with a relatively lower suction pressure to see whether the nodular variceal protrusion bulb will be formed easily. However, this method did not work this time. It is a pity that no related reports of the same complication can be found in the literature.

(2) Once you began to ligate such varices, when to stop the procedure (if possible) and how to treat the subsequent massive bleeding are the two important points you have to lay emphasis on: Yes, these are very important points. As to our knowledge, since it is the first report of this kind of complication, it is really hard to decide when the procedure should be stopped and which method should be used to cease the bleeding. We think if the physicians feel that the esophageal varicose vein is too hard when they compress the esophageal varicose vein gently using the transparent cap or when the nodular variceal protrusion bulb can't be formed easily, the procedure should be stopped and another ligation site should be selected, however, this method failed to work in this case. We gained the cessation of the bleeding via endoscopic variceal sclerotherapy. However, if

endoscopic variceal sclerotherapy failed to work, we think that the Sengstaken-Blakemore tube be employed and a following transjugular intrahepatic portosystemic shunt operation or a following surgical operation should be considered.

(3) I believe that, as this case was the first one to report this complication, we can' t affirm that there was a cause effect relation, and also, if there is an increased risk of esophageal varices bleeding during EVL in patients with previous gastric varix obliteration with glue that have migrated to esophagus varix: Yes, more cases are demanded so that an exact cause effect relation can be drawn; however, this case indicated that the emboli in the varix may increase the risk and physicians should keep in mind that this may be harmful and dangerous!

(4) A great deal of language polishing must be performed and there are a lot of typographical errors: We have requested an English language expert to help us. Thank you for your advices!

3 References and typesetting were corrected.

Thank you again for publishing our manuscript in the *World Journal of Gastroenterology*.

Sincerely yours,

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