

Format for ANSWERING REVIEWERS

February 23, 2015

Dear Editor,



Please find enclosed the edited manuscript in Word format (file name: 13807-review.doc).

Title: Pancreatectomy and splenectomy for a splenic aneurysm associated with segmental arterial mediolysis

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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) From the anamnesis of the patient there is no information why the patient was investigated 2 weeks ago.

→When the patient had been admitted for treatment of a left renal infraction, he was performed enhanced computed tomography. Then, the aneurysms were not present.

(2) What kind of renal infraction the patient was admitted for 3 days ago?

→The patient discharged three days before. After discharge, he came to our hospital with a complaint of abdominal pain. He was received balloon angioplasty because the ventral branch of the left renal artery had been dissected by the angiography.

(3) There are scarce data in the text regarding the postoperative complication pancreatic fistula and the results of its treatment.

→On day 9, he was treated with an antimicrobial agent (Vancomycin: 1 g/day) for 10 days because the abscess culture demonstrated coagulase negative staphylococcus. In addition, we performed abscess drainage for 28 days postoperatively.

(4) More detailed information is missing how you dealt with the aneurysms in common hepatic, left gastric, gastroduodenal, left renal, and both internal iliac arteries.

→SAAs (except splenic artery) are followed up with a short time period because the risk of rupture is low.

(5) It is unclear what the authors intended to present in this case report. Are the new findings uncommon recurrent rupture or the successful surgical treatment? If the former, the authors should discuss why their first intervention failed, and if the latter, the authors should provide literature review more deeply.

→We considered that the angiography did not demonstrate extravasation because our patient was hemodynamically unstable. As a result, endovascular management serves as a reliable, minimally invasive treatment option and may also provide a temporary solution before definitive surgery at a later date.

(6) Infraction should be infarction?

→I corrected to renal infarction.

(7) The level of CT scan presented in Fig 1b is not the same as that of Fig 1a, because cranial part of the right kidney seen in Fig 1b is not seen in Fig 1a.

→I corrected Fig1.

(8) Six SAAs should be numbered in the corresponding photos. Arrows indicating the splenic, left gastric, and

common hepatic arteries should be inserted.

→ I added new figure as Fig 2.

(9) Fig 2c should be resubmitted, to show the splenic, left gastric, and common hepatic arteries more clearly at post-embolization.

→ Fig 2c was resubmitted as Fig 3c.

(10) Each structure of ruptured aneurysm should be labeled in Figs 3a and 3b.

→ Each structure of ruptured aneurysm was labeled in Figure 4.

(11) The agents used in TAE should be described. If the agents are radiologically seen, the photos in which aneurysm was successfully embolized should be provided.

→ I described in Fig 3 (c).

(12) The two most important issue with regards to your case are: (a) diagnosis of left renal infarction (b) what happened in 2 weeks after initial TAE Many soft issues also need to be clarified to readers of case.

→ (a) We performed angiography. The patient was received balloon angioplasty because the ventral branch of the left renal artery had been dissected.

(b) We considered that the angiography did not demonstrate extravasation because our patient was hemodynamically unstable. As a result, endovascular management serves as a reliable, minimally invasive treatment option and may also provide a temporary solution before definitive surgery at a later date.

(13) Mention here if splenectomy was done – mention in the title itself if spleen was removed or preserved.

→ The title of this article is "Pancreatectomy and splenectomy for a splenic aneurysm, associated with segmental arterial mediolysis".

(14) Usual we just say as transarterial embilization and no need to use word 'catheter'.

→ I corrected to 'transarterial embilization'

(15) Does the author mean to convey that 'dissection' means a tear inintima and 'mediolysis' mean a tear in tunica media of artery?

→ 'Dissection' associated with segmental arterial mediolysis means a tear in tunica media of artery.

(16) Do the authors believe that these all aneurysms developed over the two weeks?

→ Figure 1 showed that splenic artery was normal two weeks ago.

(17) Is the recent admission with abdominal pain related to this aneurysms?

→ The first admission is related to the renal infarction.

(18) How was 'renal infarction' diagnosed?

→ CT and angiography revealed.

(19) What was used to embolize?

→ Figure 3 showed.

(20) What happened during these 2 weeks?

→ After TAE, we followed up the aneurysms via enhanced CT scanning, and there was no extravasation or enlargement.

(21) What were his hemodynamics at readmission or rerupture event? Why was angioembolization not offered?

→ We performed an emergency operation due to unstable vital signs.

(22) Why was distal panc needed?

→ he underwent distal pancreatectomy and splenectomy because the aneurysm was located within the pancreatic body, and the resection of splenic artery was difficult.

(23) What is your plan for the other site aneurysms that are seen on imaging?

→ SAAs (except splenic artery) are followed up with a short time period because the risk of rupture is low.

(24) What was the aetiology of spontaneous renal infrction?

→ We diagnosed SAM based on clinical and pathological findings.

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

Sincerely yours,

A handwritten signature in cursive script that reads "Yasuhiro Matsuda".

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