December 2, 2018

To the editors of the *World Journal of Hepatology.*

Dear Editors:

We are re-submitting an article entitle, "**Two-stage liver transplant for ruptured hepatic adenoma: A Case Report**" after careful revision. We thank the reviewers for their comments, and have revised the manuscript to in response to comments from each:

Reviewer 1:

1. The authors have mentioned an adenoma involving whole liver, right lobe right going into left at different places in the manuscript. Should be changed to describe the segments involved.

   All segments of the liver were involved, only a portion of the left lateral lobe (segments II and III) remained. We have added this to page 7, paragraph 1. We have carefully reviewed the manuscript to ensure this is consistent throughout.
2. The authors have not mentioned the volume of the un-involved liver and why an resection of the involved part of the liver would not have sufficed… Hepatectomy and supra-urgent listing may be appropriate in parts of the world with good donation rates and list prioritization.

   In this case, there was only a small thin remnant of viable liver along the left lateral segment at the periphery; however, this small amount of tissue was not enough parenchyma to consider resection of the liver as a viable option. The remainder of the parenchyma was not viable due to ischemic damage. We have added this to page 7, paragraph 2. Extended resection thus could not have been considered. Living donor could have been considered if there was a suitable donor available, however, we were fortunate in our case to have an organ available quickly.
3. Did the celiac dissection worsen post DSA, leading to occlusion of left artery as well? And did that contribute to the decision for total hepatectomy?

   Massive hepatic necrosis with continued mass effect on the remaining liver made the liver

nonviable and unsalvageable; this is why the decision was made to perform total hepatectomy. We have clarified this on page 7, paragraph 2 and page 9, paragraph 2.

4. CT image both the initial and post embolization should be included.
   We have now added CT images prior to embolization to this text. One CT was performed after intervention. Unfortunately, when I went to acquire images, it appears these images have been corrupted and are unavailable.

Reviewer 2:

1. The histology of resected liver should be described more detail. The possibility that pre-operative embolization is associated with the changes should be discussed.
   Additional pathology from the explanted liver had been added on page 7, paragraph 2. We have added a comment that embolization may have contributed to these changes in the discussion on page 8 paragraph 3. It is our feeling in this case that it was the combination of the embolization procedures and the mass effect of the engorged liver on the hepatic vasculature that caused the ischemia.
2. Repeated embolization might be harmful for such cases. Earlier hepatectomy might be preferred for such cases.
   While two embolization procedures were performed at an outside hospital, only one was performed in our facility. Given the morbidity associated with hepatectomy, ensuring that further embolization would not be helpful seemed the prudent management initially. However, as it became clear that this did not help, the decision to proceed with surgical management and hepatectomy was made rapidly. We added this on page 10 paragraph 2.

All relevant changes to the manuscript have been highlighted in yellow. Thank you for the opportunity to revise our submission.

Sincerely,
Mark Pedersen