

Dear Editor,

The manuscript has been revised according to the journal's guideline and peer-reviewers' comments

Reviewer's code: 03730369

SPECIFIC COMMENTS TO AUTHORS

Many previous papers proved that T-tubes used for biliary anastomosis can be seen responsible for many complications. Why in your case was this technique chosen? What was the quality of recipients distal bile duct in order to long lasting HAT. When was T-tube removed and what is current status of patients bile duct (TBIL level)?

Answer: Thank you for your valuable advice. Indeed, placement of the T tube may pose a potential risk of biliary complications. However, with the increasing number of cardiac death donors, the incidence of biliary tract complications caused by hot ischemia is relatively high. In our center, conventional placement of the t-tube can facilitate following biliary catheter drainage or choledochoscopy treatment through the sinus canal formed by the t-tube once serious postoperative ischemic bile duct complications occur. Thus, PTCD and ENBD can be avoided. Despite the early formation of thrombus in the artery, the recipient side bile duct showed no abnormal. Cholangiography showed no abnormal 3 months after surgery, and the biliary drainage tube was removed according to the routine of our center. Bilirubin level was normal.

Reviewer's code: 02944278

SPECIFIC COMMENTS TO AUTHORS

Well written paper, nice photos and illustration. Unfortunately these technique has already been described several years ago.

Answer: Thanks for your comments! Although it has been technically reported, the possibility of simultaneous occlusion of the hepatic artery and portal vein after liver transplantation was very small, and the difficulty caused by the

second liver transplantation operation was not small.

Reviewer's code: 02546836

SPECIFIC COMMENTS TO AUTHORS

This is a case report of the consequences of long term ischemia in OLT causing a biliary stricture and ultimately liver failure. It reads well and has basically proper grammar. It needs some clarifications. 1) Was the Hepatitis B active or considered cured during the 1st transplant? 2) What was the nature of the biliary stricture. Small duct or anastomotic or other? The changing of PTC stents could have caused chronic cholangitis. Did the patient have frequent biliary infections? 3) Was there a bile leak after the first surgery?

Answer: Thanks for your valuable comments! Hepatitis B virus had been cured before the 1st liver transplant because the HBV-DNA was negative. Biliary stricture was caused by diffuse ischemic necrosis of the bile duct in graft liver and bile duct endothelial cells fall off after hepatic artery occlusion, which leads to blocking the bile duct. Therefore, the patient needed to replace the biliary drainage tube regularly (average every 2 months). If the time lasted too long and the biliary drainage tube will be blocked, the patient will have a marked increase in bilirubin index accompanied by fever. After the first operation, repeated cholangiography did not reveal the presence of biliary leakage.