

■1st reviewer

I read the manuscript presented with interest, the cases are well presented and well documented, however is it possible to find in the current literature more than 60 similar articles describing the same cases, I think that the discussion is too short and that the manuscript could have an interesting value adding the complete review of cases previously published, otherwise it add nothing to the current literature. Regards.

We reviewed the aforementioned previous case reports and added a discussion in detail.

■2nd reviewer

Q1. The author reported 2 case of Meckel's diverticulum with mucosal bleeding. They were diagnosed intussusception by CT scan. Why the author didn't use gastrointestinal bleeding scintigraphy? Recently, some papers reported the diagnostic advantage of CT angiography for GI bleeding included Meckel's diverticulum. The author should mention about this point in discussion

We also agree with your opinion. Intermittent and/or small amounts of GI bleeding can be easily detected by Tc^{99m} RBC scintigraphy, where the minimum detectable bleeding rate was reported as 0.05-0.2 mL/min; relatively stable persistence in the circulation made it possible to monitor of patients with intermittent bleeding.¹¹ Scintigraphy could have been used to locate the bleeding focus in the 1st case. However, according to the gastroenterologist, they initially thought that the chronic intermittent hematochezia in this patient was due to a hemorrhoid. That was why the patient was followed by a local gastroenterology clinic for 1 year. Subsequently, the patient was admitted to the emergency room complaining of hematochezia with abdominal pain. CT scan was used to evaluate the cause of left lower quadrant pain but not the hematochezia in this case. In the 2nd case, scintigraphy could have been used to evaluate the cause of melena. However, the gastroenterologist decided on capsule endoscopy, revealing gastrointestinal bleeding in the small intestine. According to the gastroenterologist, scintigraphy was not considered at that moment because the bleeding from the small intestine was already confirmed by capsule endoscopy and because CT scan is performed to reveal underlying pathologies causing GI bleeding in adults. CT angiography can be considered if the GI bleeding is active. The detection limit of CT angiography for active bleeding was 0.3 ml/min in porcine models. Our cases were regarded as having chronic and intermittent GI bleeding, not active bleeding.

Q2. The author used CT scan to diagnose the intussusception. Some paper reported the useful of abdominal ultra sonography to diagnose the intussusception. Abdominal US is easy and non invasive examination. And characteristic target sign is easily detected when intussusception is existed. Why the author didn't use abdominal US? If they used abdominal US, the author should be mentioned about it

We also agree with your opinion. In young ages, abdominal US could be the 1st diagnostic tool. It's easy and non-invasive. But both our cases were adult. In adult, underlying pathologies are diverse

such as lymphoma, lipoma, other malignancies. Therefore, CT scan is the 1st recommended diagnostic tool in adult intussusception to discriminate its cause. In addition, unfortunately, radiologist in our country who was trained in abdominal US was usually unavailable at night.

Q3. Although, the author used capsule endoscopy in case 2, the findings of this examination didn't lead exact diagnose and the video quality of it was too low. Why the author used capsule endoscopy in case 2

This is why our case report is meaningful. Even though our gastroenterologist had 30 years' experience, they performed capsule endoscopy in the 2nd case. They expected to find small bowel pathology but failed to do so. Apart from low video quality, if the capsule was obliterated by small bowel pathologies, the patient might experience intestinal obstruction, leading to increased morbidity related to surgery. Following this report, we hope clinicians worldwide will be cautious regarding use of capsule endoscopy to evaluate the cause of GI bleeding in adults. We mentioned it in discussion.

Q4. The author performed side-to-side stapled anastomosis in case 1. However, the author performed end-to-end anastomosis in case 2. Why is the anastomotic procedure different between two cases?

The 1st case had proximal bowel edema but the distal bowel had a normal bowel. The disproportion of bowel diameter made us decide side-to-side bowel anastomosis. The 2nd case had an intussusception without bowel edema. So End-to-End anastomosis was easily performed.

■3rd reviewer

The authors present two interesting case reports about a rare presentation of an uncommon congenital anomaly. The overall structure of the manuscript is complete. The title is concise and well-written, and three key words have been included. The cases are well described, with good quality images of the diagnostic and therapeutic procedures. Good quality histologic images have been included. Diagnosis and treatment are discussed. Observations: The abstract should include information such as definition, epidemiology and clinical presentation. This information can be obtained from the introduction section. The authors declare that all participants provided informed written consent. A conflict of interest statement has been included. No misconduct has been observed. Conclusions: The authors present two interesting case reports about a rare presentation of an uncommon congenital anomaly. The manuscript is concise and comprehensive, with potential value for publication, provided that the authors follow the recommendations.

Q1. In case 1 (line 10), the authors mention that “a polyp-like mass was exposed (Figure 1B)”. This seems to be a finding once the segmental small bowel resection was completed and the intraluminal aspect was inspected. The extraluminal surgical finding upon laparoscopy

should be described first and after the resection and anastomosis description, the intraluminal finding could be described instead.

We also agree with your opinion and have changed it clearly

Q2. In case 2 (line 13), the authors describe that “a large polip-like mass with mucosal ulceration at the tip was inverted into the small bowel”. At the moment, since a diverticulum was not confirmed yet, it is not appropriate to describe the finding as “inverted”.

We also agree with your opinion and have changed it clearly

Q3. In Figure legend: Figure 1 B, the code in the superior right corner should not be shown, in order to avoid any possible case identification.

We also agree with your opinion and have changed it

Q4. Figure 1C, stain and magnification for histopathology figure should be described.

We also agree with your opinion and have changed it

Q5. In Figure 3 B, the code in the superior right corner should not be shown, in order to avoid any possible case identification.

We also agree with your opinion and have changed it clearly

Q6. Figures 2 and 3 could be included in the single figure panel with the corresponding legends.

We have combined figure 2 and 3 as you mentioned.