Dear Sir/Ma'am,

Thank you for the notification.

According to the Editorial Office's comments and suggestions, we have made the following responses to the issues raised in the peer review report.

1. The paper is not structured accrding to Author's Guidelines.
The manuscript has been updated according to the Guidelines and Requirements for Manuscript Revision and the Format for Manuscript Revision for the specific manuscript type: 'Case Report'.

2. Abbreviations are not fullt explained at the first mention.
We have revised the manu accordingly.

3. English language requires a native speaker revision.
Thanks for the suggestion. We have a native-English speaker edit the manuscript for grammar, sentence structure, word usage, spelling, capitalization, punctuation, format, and general readability.

4. It is unclear whether steroid therapy provoked the disappearance of nasal pyderma vegentans or only of related local pain.
The steroid therapy did provoke the disappearance of the nasal pain. Due to the COVID-19, the patient did not come back to our hospital for re-examination. The patient was followed-up by telephone only. Anyway, thanks a lot for your advice. The patient has been suggested to come to the local hospital to visit ENT doctor and have the nasal examination once more.

5. Why at the first diagnosis, presumably occurred for clinical active disease, the patient was treated only with mesalzine? Was clinical remission supported by endoscopy/histology or by fecal calprotectin assay? • Why Authors did not consider biological treatment?
The initial treatment strategy in ulcerative colitis typically follows the traditional step-up approach. 5-ASA remains the mainstay of conventional therapy. Systemic corticosteroids are appropriate in patients with moderate to severe activity who do not respond to mesalamine. In non-responders who have no response to intravenous steroids, treatment options including ciclosporin, infliximab, tacrolimus, or surgery should be considered.
This patient had good response to steroids. The clinical remission was supported by colonscopy, which had been indicated in the manu. However, for the ulcerative colitis patients with EIMs, biological treatment was strongly suggested. The biological treatments in China are very expensive. Considering the expensive medical cost, the patient rejected the biological treatment. Of noted, from Jan 1, 2020, the price of

Inflaximab had been reduced a lot and also Inflaximab could be covered by medical insurance. More and more severe ulcerative colitis patients could get benefit from the new policy.

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6. What about the presence of pyiderma in sides other than nose after steroid treatment?

The patient was healed from PG and the skin lesions were completely cleared afer steroid treatment. We have modified the manu accordingly.

7. A section explaining details of this skin lesion is required.

Thanks a lot for the advice. We have added the explaining details of the skin lesions in the revision.

8. IBD specialists encounter many cases of cutaneous form of IBD extraintestinal manifestations such as erythema nodosum, psoriasis, eczematous lesion and many opportunistic skin or mucosal infections, which are sometimes fatal to the IBD patients. Your case is a extremely rare form of extraintestinal manifestation, but it's original and informative. Because of its rarity, reviewing seems to be sufficient, but I think your case is acceptable. Treatment of PV is not established, but if you give some more treatment experience in detail, it will be better. For example, steroid duration was 3 months, it seems to be longer than traditional steroid regimen. Moreover, if there was a trial of antibiotics, please show us your experience and its response. thank you.

This patient had two kinds of EIMs. One is Pyoderma gangrenosum, and the other is Pyoderma vegetans.

Pyoderma gangrenosum can be treated with systemic corticosteroids, infliximab or adalimumab, or topical or oral calcineurin inhibitors. As for this patient, local wound care with fibroblast growth factor gel and sodium fusidate ointment were given daily, besides the steroid treatment. The treatment details were given in the revision accordingly.

There are no standard treatment modalities for PVs. Systemic steroids and local wound care could control the disease. Considering the patient having severe UC accompanied with EIMs, we suggested her using infliximab, which is an appropriate

option for the patient who does not respond to routine treatments. However the patient refused the infliximab treatment due to the expensive costs. Finally, the patient got better with the treatment of systemic steroids. Luckily, she had no recurrent attacks after 1 year of follow-up.

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(1) Marcus Harbord, Vito Annese, Stephan R Vavricka, Matthieu Allez, Manuel Barreiro-de Acosta, Kirsten Muri Boberg, Johan Burisch, Martine De Vos, Anne-Marie De Vries, Andrew D Dick, Pascal Juillerat, Tom H Karlsen, Ioannis Koutroubakis, Peter L Lakatos, Tim Orchard, Pavol Papay, Tim Raine, Max Reinshagen, Diamant Thaci, Herbert Tilg, Franck Carbonnel. The First European Evidence-based Consensus on Extra-intestinal Manifestations in Inflammatory Bowel Disease. J Crohns Colitis, 2016 Mar;10(3):239-54.

Thanks & Best regards,

Jinghua

Re-review:

Considering the patient having severe UC accompanied with EIM, we suggested her using infliximab, which is an appropriate option for the patient who does not respond to routine treatments. However the patient refused the infliximab treatment due to the expensive costs. Finally, the patient got better with the treatment of systemic steroids. Luckily, she had no recurrent attacks after 1 year of follow-up.