Responds to the reviewer's comments:

Reviewer #1: The author reported a rare anomaly of the right-sided sigmoid colon with carcinoma. The author described the patient's clinical data and treatment process in detail. In fact, the sigmoid colon located in the right abdomen is not uncommon. Most of them are not due to abnormal development, but to the long sigmoid colon. When the lengthy sigmoid colon develops a tumor that penetrates the serous membrane and invades the right abdominal wall, the sigmoid colon is located in the right abdominal cavity. This is not a rare case clinically. The direction and location of sigmoid colon can be determined by continuous CT scanning. Therefore, this case report is of little significance for clinical guidance. In addition, there are not enough pictures in the article, and intraoperative exploration pictures are not provided, which cannot give readers an intuitive understanding.

1. Response to comment: The sigmoid colon located in the right abdomen is not uncommon. Most of them are not due to abnormal development, but to the long sigmoid colon

Response: It is really true as reviewer #1 mentioned that the sigmoid colon located in the right abdomen for its redundancy is not uncommon, but the right-sided sigmoid colon due to abnormal development is really rare. In our case, the abnormal course of descending colon, ileocecal junction and inferior mesenteric artery indicating that may be related to midgut malrotation, fixation anomalies, or secondary rotation of the colon during embryogenesis, so that we report a rare anomaly.

2. Response to comment: there are not enough pictures in the article.

Response: Considering the Reviewer #1's suggestion, we have added a MIP image as Figure 2B. We feel very sorry for that we could not find an appropriate intraoperative exploration image compatible with the CT reconstructed image due to some technical reason. Thanks for your comments.

Reviewer #2: An interesting article on a carcinoma found on the right-sided sigmoid colon through preoperative CT. The authors suggested that it is imperative for physicians to be able to understand variations in the sigmoid colon to prevent misdiagnosis and inappropriate treatments. Content wise, the article presents adequate information for readers to understand its objectives and compare its findings with other differential diagnosis. Moreover, no major errors were found in terms of the article's structure and grammar. A few things that could be added to the manuscript: 1. What was the patient's race? Could this particular race be related to sigmoid variations found in this patient? 2. Please mention the limitations in your approach of this case.

1. Response to comment: What was the patient's race? Could this particular race be related to sigmoid variations found in this patient?

Response: The patient's race was Chinese Han, we added it in our article. The sigmoid variation in length is related to racial differences, but there is a lack of studies investigating whether or not the race is related to this rare sigmoid variation. Special thanks to the

reviewer's good comments.

2. Response to comment: Please mention the limitations in your approach of this case.

Response: We have added limitation in our approach.

Reviewer #3: Line 29 please precise that a left hemicolectomy have been performed by an open way after conversion to a laparotomy in a clear language. Line 35: Please precise clearly the type of complications that prior knowledge of this anatomical variety can prevent Line 90: Please give a complete TNM classification of the tumor and precise the UICC Stade. Lines 139, 140 and 141: There is a big contradiction: The diagnosis of right sided sigmoid tumor have been down after laparoscopic exploration never at the CT preoperative exploration. Please reformulate this paragraph. This big contradiction can make your good work rejected be careful! we would have liked to have had intraoperative photos of this rare anatomical condition. Why gastroenterologists did not perform biopsies on the colonic striction located 28 cm from the anal margin.

1. **Response to comment:** Line 29 please precise that a left hemicolectomy have been performed by an open way after conversion to a laparotomy in a clear language.

Response: We have made correction according to the comments.

2. **Response to comment**: Line 35: Please precise clearly the type of complications.

Response: We have added it in our article, and the main complication was caused by surgical errors due to incorrect preoperative diagnosis.

3. **Response to comment:** Line 90: Please give a complete TNM classification of the tumor and precise the UICC Stade.

Response: We have added a complete TNM classification of the tumor and precise the UICC Stade in our case report.

4. **Response to comment:** Lines 139, 140 and 141: There is a big contradiction, please reformulate this paragraph.

Response: We have re-written this part according to the suggestion. We gratefully appreciate for the valuable comment.

5. **Response to comment:** we would have liked to have had intraoperative photos of this rare anatomical condition.

Response: We feel very sorry for that we could not find an appropriate intraoperative exploration image compatible with the CT reconstructed image due to some technical reason. But we have added a MIP image as Figure 2B for supporting detail. Thanks for your friendly and sincere comments.

6. **Response to comment:** Why gastroenterologists did not perform biopsies on the colonic striction located 28 cm from the anal margin

Response: The colonoscopy could not went through the stricture and a biopsy was performed, indicative of malignancy, and we added it in our case report. Special thanks to the reviewer's good comments.

We appreciate for Editors/Reviewers' warm work earnestly, and hope that the correction will meet with approval.

Once again, thank you very much for your comments and suggestions.

Sincerely yours,
Liang-jing Lyu, Wei-wu Yao.