Reviewer #1:

Comments: Case reported is rare and unusual, its draws the attention of surgerons of this uncommun situation.

Response:

Thank you for your approval.

Reviewer #2:

Comments:

Dear authors, It is well written rare case. Fortunately everything went fine. It would be great if you explained the procedure. And some photos of them, before and after treatments.

Response:

Thank you for your approval.

We added some surgical details.

“During the operation, 30 ml of grey and smelly pus was drained from the deep surface of the sternocleidomastoid muscle. There was not any main artery was exposed in the operation field, and no suture or ligation. After the purulent cavity was cleared, iodophor gauze was stuffed into the space. The incision was not sutured.”

No photographs were taken during drainage of the abscess. Because the operation went smoothly, and there was nothing special to be pay a attention to. When the incision bleeding, the situation was urgent and the patient and his families were very anxious, so there is no time to take photos. We hope you understand. This is a lesson learned from a case of chronically infected external carotid artery occlusion and rupture, and suggested that surgeons need to pay attention to vascular lesions caused by chronic infection that may develop into acute CBS.

Science editor:

Comments:

The authors report a case of carotid blowout syndrome. This is a rare syndrome and of scientific interest. Writing in the english language is appropriate, but more information on the case presented is necessary. When an abbreviation is presented for the first time in the manuscript, it must be written in full (such as CT in page 2). In the imaging examinations description, it would be interesting to retrospectively assess the relationship between the abscess and the carotid artery in the preoperative CT and ultrasound. More detailed information could also be presented regarding the two surgical procedures - what was the draining procedure like, what kind of drain was placed if any, and how was carotid embolization performed and at what level. The main issue that must be raised is whether the abscess itself was the cause of the carotid lesion or if there could be a relationship to the drainage procedure.

Response:

Thank you very much for your valuable comments.

We had added this information and revised the manuscript according to the guidelines.

“We diagnosed the condition as neck infection with abscess formation based on physical examination, routine blood examination, ultrasound examination and plain CT and decided to perform emergency surgery. During the operation, 30 ml of grey and smelly pus was drained from the deep surface of the sternocleidomastoid muscle. There was not any main artery was exposed in the operation field, and no suture or ligation. After the purulent cavity was cleared, iodophor gauze was stuffed into the space. The

incision was not sutured.

When CBS caused by chronic infection of the left external carotid artery (ECA) was considered. The patient was transferred to a vascular unit for transcatheter ECA embolization. Under general anesthesia, the left ECA angiography indicated the significantly localized expanded ECA. Then, a Guglielmi detachable coil was used to occlude the initial part of ECA completely. Postoperative immediate angiography confirmed the complete occlusion of the left ECA. Bleeding stopped after the procedure without any complications."

We concluded that there was no significant relationship between the carotid lesion and the abscess drainage procedure. Instead, the left ECA occlusion and rupture was associated with chronic infection. We described this in discussion.