Round 1

Reviewer 1

You are a very patient and kind reviewer. You pointed out a lot of problems for me in detail, revised them one by one according to your suggestions, and the content of the whole manuscript improved a lot. I would like to express my heartfelt thanks and sincere greetings here.

1. Abstract under CASE SUMMARY: place (LST) after laterally spreading tumor (LST) of the rectum.

Answer: Thank you for your suggestion. The (LST) location has been adjusted according to your request.

2. Abstract under CONCLUSION: Suggest revision to: "For patients with complicated delayed perforation in the lower rectum but have an adequate intestinal preparation, SECMS combined with TIDT can be used and may obtain a very good outcome."

Answer: Thank you for your good suggestion. It was revised according to your suggestion. I feel the meaning is clearer.

3. Under Core tip: "5 cm away from the anal orifice, and below the peritoneal (reversal)" You meant peritoneal reflection?

Answer: Yes, here, Peritoneal reversal refers to peritoneal reflection, but this expression is not common. Thank you for pointing out this problem. Two places of Peritoneal reversal in the article have been changed to peritoneal reflection.

4. INTRODUCTION:

- Acute iatrogenic colorectal perforation (AICP) is a serious adverse event, but it is rare – Can you enumerate common cause of AICP?

Answer: the common causes of perforation include mechanical injury during colonoscopy insertion, deep cauterization during therapeutic colonoscopy, and intestinal wall tearing during endoscopic balloon dilation. The above contents have been added to the introduction.

- Different presentation if perforation was in Colon vs Rectum / or this is focused on Rectal perforation only?

Answer: In most cases, the clinical features of colorectal perforation (colon and rectum) are similar, showing a large amount of peritoneal free air, which may accompany peritonitis. The severity of symptoms depends on whether intestinal contents leak into the abdominal cavity. The only possible difference is that peritonitis may not occur when perforation occurs below the peritoneal reflection. This manuscript mainly focuses on rectal perforation, so the clinical features of colon and rectal perforation are not introduced in detail.

- OTSC (overthe-scope clips) to (over-the-scope clips)

Answer: Dear reviewer, thank you for pointing out this small mistake. I have corrected it.

- Incidence of Perforation rectal tumor ESD?

Answer: Dear reviewer, at present, there is no separate report on the incidence of ESD-related perforation of rectal tumors. Many existing studies are about the incidence of ESD-related perforation of colorectal tumor, which is mentioned in the following discussion and is about 4-10%.

5. CASE PRESENTATION:

- Physical examination: Role of dexamethasone injection?; Change P 81 times/min to “Pulse rate of 81/min”;

Answer: patient had developed toxemia at the local hospital and dexamethasone was used to relieve the toxemia ; The expression was changed according to your suggestion.

6. What was/were the side effect(s) of a low-rectum SECMS? Was there tenesmum?

Answer: Fortunately, the patient did not develop significant side effect s of low-rectal SECMS, which included anal pain and tenesmus， only some anal discomfort. It is reported that about 15% of patients have anal pain after placing rectal stents[1]. Some of the above contents have been added to the TREATMENT paragraph in the manuscript.

7. Considering that the anastomosis was covered by a metallic stent, was not putting a TIDT an option?

Answer: Your question is actually very good. It is indeed an option not to place TIDT. However, this patient's condition is complicated. In order to pursue a higher success rate

of treatment, we chose metal stent combined with TIDT, because it is reported that the success rate of treating anastomotic leakage with metal stent alone is about 80%, while TIDT alone has a certain failure rate. So in order to improve the success rate, we use the combined method.

8. What are the other options for rectal perforation (aside from endoscopic)?

Answer: There are several therapeutic methods for rectal perforation, including endoscopic repair, conservative or surgical operation. Extremely small perforation can be treated conservatively. In addition, surgical treatment can also be selected for perforation, including perforation repair, partial rectal excision, fecal bypass operation, etc. The appropriate treatment can be decided according to different situations. These contents are mentioned in the discussion section.

Reviewer 2

Thank you for your submission. Your manuscript is not well organized and does not follow a clear flow. Please see the following comments about how your data could be further clarified:

1. The title of the article is very long and this length makes it difficult to understand the subject.

Answer: Dear reviewer, thank you for your suggestion, but we don't agree with this point. Here, we think that the title of this article is not long. The main reason why it looks long is that the instrument name mentioned in the title is relatively long. If the instrument name in the title is changed to abbreviation, Then the title will become the following form " SECMS combined with TIDT in the treatment of a complicated delayed rectal perforation after ESD: A case report", so the theme of the title is not difficult to understand. If the title is forcibly shortened, a lot of key information will be lost. In addition, it is reported in similar literature that self-expanding covered stent are used to treat rectal explosive injuries. With the following title: " Use of self-expanding covered stent and negative pressure wound therapy to manage late rectal perforation after injury from an improvised explosive device: a case report[2]",the title of this manuscript is 27 words,

while the title of our article is 26 words, so the length of the title will not affect the understanding of the subject.

2. The purpose written in the introduction is very long and contains unnecessary content.

Answer: Thank you for your review. Some of the contents in the introduction are really long. This part has already appeared in the abstract, so it can be simplified as necessary, mainly optimizing the introduction of the patient's condition in the introduction.

3. The number of figures presented in this draft is very large, and some of them do not present a specific subject and content, but will confuse the reader more.

Answer: Thank you for your suggestion, I have optimized the theme and content of the chart, including figure 1, figure 4, figure 5, figure 6

4. The content presented in the discussion section is very long and tedious, and the content is discussed outside the topic.

Answer: Thank you for your comments. We carefully re-read the contents of the discussion section. Some of the contents are really lengthy. The main reason is that the patient's condition has been repeatedly emphasized, and the patient's condition has been explained in the case presentation. Therefore, according to your comments, we deleted the contents that may be repeatedly emphasized. There is another part of the content you proposed that seems irrelevant to the theme, and we have optimized it accordingly.

5. The working mechanism of this tool and method is not explained at all. It is even necessary that the working mechanism of this method or tool be discussed.

Answer: Thank you for your suggestion, in fact the working mechanism of this tool has been mentioned in the discussion, but more scattered, according to your suggestion, the working mechanism into a separate paragraph. In the fourth paragraph of the discussion.

6. With these descriptions, I did not see any significant novelty in this work.

Answer: Although both stents and TIDT have been reported for the treatment of rectal anastomotic leakage, they have not been used for perforation after ESD, and the combination of them has not been reported, so this is the first report in the world, and good results have been achieved.

References

1 Lamazza A, Fiori E, Schillaci A, Sterpetti AV, Lezoche E. Treatment of anastomotic stenosis and leakage after colorectal resection for cancer with self-expandable metal stents. *The American Journal of Surgery* 2014; **208**: 465–469. [PMID: 24560186 DOI: 10.1016/j.amjsurg.2013.09.032]

2 Ozer MT, Coskun AK, Sinan H, Saydam M, Akay EO, Peker S, Ogunc G, Demirbas S, Peker Y. Use of self-expanding covered stent and negative pressure wound therapy to manage late rectal perforation after injury from an improvised explosive device: a case report. *Int Wound J* 2014; **11**: 25–29. [PMID: 24851734 DOI: 10.1111/iwj.12287]

Round 2

Comments: Thanks for editing and answering the authors. The cases and points corrected by the authors in the manuscript are not very recognizable. And according to my review, many cases were not corrected. Please highlight the corrected items in the text Also upload modified shapes. By the way, I do not mean that the title of the article should be written in abbreviated form.

Answer: A number of errors have been corrected as recommended by reviewer 1. Another manuscript was uploaded. Manuscript has been modified using Microsoft Word Track Changes mode, many of changes are expected to be visible to you.Thank you again for your careful review.