

Dear Editors and Reviewers:

We are truly grateful to your critical comments and thoughtful suggestions on our manuscript. Based on your positive and constructive comments and suggestions, we have made careful modifications on our original manuscript, and the correction sections in the revised manuscript are marked in red for easy checking. Below you will find our point-to-point responses to the the editor's and reviewer's comments.

Responds to the reviewer's comments:

Reviewer #1:

Response to comment: This is a well-written article about colonic duplication

Response: We appreciate your suggestions and comments on our manuscript.

Reviewer #2:

Response to comment: Your case report is interesting but the case presentation should be more discursive with less paragraphs

Response: We appreciate your comments. It is true as Review suggested that our case lacks concise and attractive description about colonic duplication. We hence carefully revised the case presentation section as follows:

A 17-year-old female patient complained of constipation and chronic abdominal pain visited our hospital. The girl presented the above-mentioned symptoms since she was a child, her constipation gradually developed to a degree that she must took medicines to facilitate defecation. The girl had been disturbed by chronic intermittent abdominal pain without radiation for years. As conservative treatments failed to improve her symptoms, so she sought definitive surgical intervention in our hospital. The physical examination revealed left lower abdominal tenderness with a normal bowel movement, and the laboratory results showed no abnormalities. The X-ray examination after oral intake of barium (Figure 1.A) suggested two enlarged loops with accumulated barium in the left lower quadrant. An abdominal CT (Figure 1.B) revealed two dilated lumen with a massive amount of stored feces in the left abdominal region. Considering clinical manifestations and imaging results, we suspected a diagnosis of colonic duplication.

A laparoscopic exploration and left hemi-colectomy were then performed. During

surgery, an intestinal loop was separated from the transverse colon adjacent to the splenic flexure and extended to the left iliac fossa with a dead end (Figure 1.C). After dissociating the mesentery from the duplicated colon, a side-to-side anastomosis was made. The histopathologic examination revealed normal alimentary structures with well-formed mucosa and a smooth muscular layer, which further confirmed the diagnosis of a tubular colonic duplication (Figure 1.D).

The patient was discharged after an uneventful post-operative clinical course. At the 6-month follow-up evaluation, the patient was doing well without nausea or constipation.

Reviewer #3:

Response to comment: Congratulations on a very rare case well managed.

Response: Thank you for your consideration and patience again.

Reviewer #4:

Response to comment: There are numbers and comments within the discussion where the bibliographic citation should be incorporated. Ex: "Nearly 90% of patients undergo surgical treatment and 68.5% of duplication are tubular" (???).

Response: We apologize for inappropriate description that may confuse readers. We deleted irrelevant descriptions and revised our manuscript with great efforts, the revised section was marked in red in our paper.

Response to comment: Finally, perhaps a systematic review with all available cases would make this paper more tempting.

Response: Thank you for your comments. We added a table (Table 2) to summarize the clinical characteristics of included literatures so as to make our results more convincing.

Thank you again for your time and consideration. We hope that the revised manuscript is qualified for publication in *World Journal of Clinical Cases*.

Thank you very much for your work concerning my paper.

Yours respectfully,

Jia-Gang Han

Table 2. Clinical characteristics of included literatures

Cases	Location	Age	Gender	Complaints	Treatment	Types	Follow-up
Ricciardolo <sup>[1]</sup>	Right colon	35	M	Acute abdomen	Right hemicolectomy	Cystic	Lost
Sobhani <sup>[2]</sup>	Sigmoid colon	27	M	Abdominal pain	Laparotomy	Tubular	Uneventful
Banchini <sup>[3]</sup>	Transverse colon	21	M	Constipation	Laparotomy	Tubular	Uneventful
Siamionava <sup>[4]</sup>	Transverse colon	18	F	Constipation	Laparotomy	Tubular	Uneventful
Wu <sup>[6]</sup>	Descending colon	25	F	Abdominal pain	Laparotomy	Tubular	Uneventful
Asour <sup>[7]</sup>	Sigmoid colon	61	M	Abdominal pain	Colonoscopy	Tubular	Uneventful
Cheng <sup>[8]</sup>	Complete colon	29	F	Abdominal mass	Subtotal colectomy	Tubular	Uneventful
Tufiño <sup>[9]</sup>	Ascending colon	36	F	Abdominal pain	Laparoscopy	Cystic	Uneventful
Garg <sup>[10]</sup>	Hepatic flexure	42	F	Constipation	Colonoscopy	Cystic	Uneventful
AbouZeid <sup>[12]</sup>	Complete colon	2	F	Rectovestibular fistula	Laparotomy	Tubular	Uneventful
Fenelon <sup>[13]</sup>	Sigmoid colon	74	F	Acute abdomen	Laparotomy	Cystic	Lost
Limas <sup>[16]</sup>	Splenic flexure	20d	M	Abdominal pain, vomiting	Laparotomy	Cystic	Uneventful
Hsu <sup>[17]</sup>	Transverse colon	40	M	Abdominal mass, pain	Laparotomy	Cystic	Chemotherapy
Kang <sup>[18]</sup>	Ascending colon	23	F	Abdominal mass	Laparoscopy	Cystic	Chemotherapy
Jimenez <sup>[19]</sup>	Ileum to colon	8	F	Abdominal pain	Total colectomy	Tubular	Lost
Ademuyiwa <sup>[20]</sup>	Ascending colon	10	F	Abdominal pain vomiting	Laparotomy	Cystic	Uneventful
Pels <sup>[21]</sup>	Complete colon	39	F	Perianal abscess	Laparotomy	Tubular	Lost
Trotovsek <sup>[22]</sup>	Transverse colon	6	F	Nausea vomiting	Laparotomy	Tubular	Uneventful
Kaur <sup>[23]</sup>	Complete colon	3m	F	Rectovestibular fistula	Laparotomy	Tubular	Recurrence
Ho <sup>[25]</sup>	Sigmoid colon	25	M	Abdominal pain	Laparotomy	Tubular	Lost
Espalieu <sup>[26]</sup>	Sigmoid colon	54	M	Constipation, pain	Laparotomy	Tubular	Lost

In the column of "Age", "20d" refers to 20 days; "3m" refers to three months; In the column of "Gender", "M" refers to male; "F" refers to female

