

Dear Dr. Xia,

We are pleased to inform you that, after preview by the Editorial Office and peer review as well as CrossCheck and Google plagiarism detection, we believe that the academic quality, language quality, and ethics of your Manuscript NO.: 57013, Case Report, basically meet the publishing requirements of the World Journal of Clinical Cases. As such, we have made the preliminary decision that it is acceptable for publication after your appropriate revision. Upon our receipt of your revised manuscript, we will send it for re-review. We will then make a final decision on whether to accept the manuscript or not, based on the reviewers' comments, the quality of the revised manuscript, and the relevant documents. Please follow the steps outlined below to revise your manuscript to meet the requirements for final acceptance and publication.

### **1 MANUSCRIPT REVISION DEADLINE**

We request that you submit your revision in no more than **14 days. Please note that you have only two chances for revising the manuscript.**

### **2 PLEASE SELECT TO REVISE THIS MANUSCRIPT OR NOT**

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### **3 SCIENTIFIC QUALITY**

Please resolve all issues in the manuscript based on the peer review report and make a point-by-point response to the issues raised in the peer review report. Authors must resolve all issues in the manuscript that are raised in the peer-review report(s) and make point-by-point responses to the issues raised in the peer-review report(s), which are listed below:

First of all, I would like to express my sincere thanks to you for your valuable comments on the revision of my article, because in the process of revision, I have gradually broadened my research ideas, gradually improved my level, and made the article more meticulous. We are very exciting to get the positive comment from the expert in this field. Thank you very much.

Reviewer #1:

**Scientific Quality:** Grade C (Good)

**Language Quality:** Grade A (Priority publishing)

**Conclusion:** Major revision

**Specific Comments to Authors:** The article is interesting because of the exceptional nature of this complication and the treatment used in 4 + 8 cases.

Thank you for the nice comments, it is very useful for our future work.

Authors should consider the following points: Keywords: They only introduce 2 MESH in the keywords: anastomotic leakage. Case report is mandatory and the authors do not consider it despite having signed it in the Care Checklist. We believe that you should consider at least the following MESH: Case report; Seminal Vesicles. The authors should substitute Rectal resection for Proctectomy; Computed tomography by Tomography, X-Ray Computed;

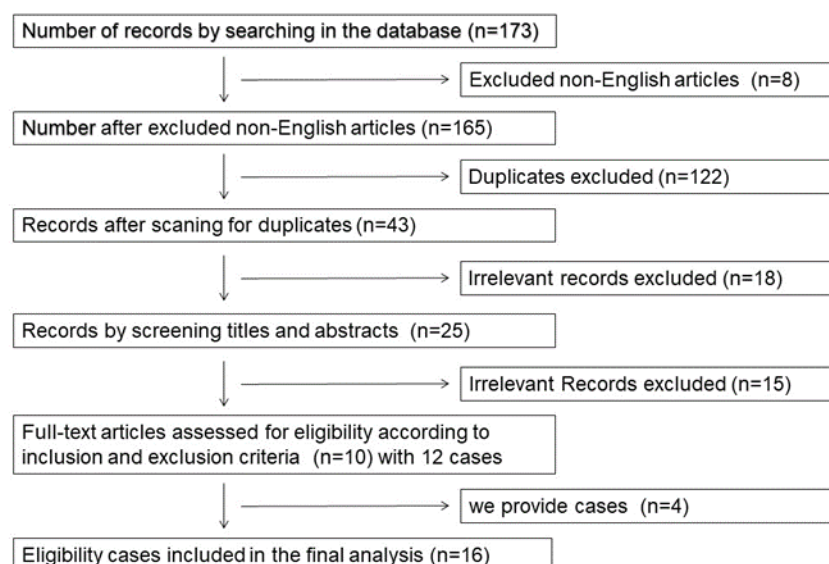
Thank you for this important question. This is one of the key issues that need to be clarified. We recheck the manuscript and correct the key words. We have revised the inaccurate language in the full text.

Key words: Case report; Seminal Vesicles; Proctectomy; Anastomotic leakage; X-Ray Computed; Tomography.

Introduction The search carried out to identify patients with a rectal vesicular fistula did not seem adequate. The authors identify the search terms, but not the strategy. It should be added. The authors do not specify how when searching the bibliography they arrive at 12 results. A flow chart with the items considered and discarded (and the reason) should be made.

Thank you for the comments. We add this part.

Table 1: Flow chart of cases screening



In clinical cases, authors should: Case 1: Clarify when they restore traffic continuity.

Thank you for the question. This is a very good question, but we have ignored it. It is not mentioned in the original text. We modify and add the following part in Case 1 section as following.

The catheter was removed, oral feeding was conducted, and intestinal traffic continuity was restored.

Wouldn't a colostomy or lateral ileostomy have been better instead of a Hartmann operation?

Thank you for the careful check. This is an important question. We add the following part in Case 1 section as following.

The patient was continued with urethral catheterization meanwhile operated with incision and drainage of right epididymis abscess but colostomy or ileostomy for fecal diversion on Pod 45. Then began to drink a small amount of water and gradually increase the amount of water to increase urine volume, reduce urinary tract infection.

Case 3: They repeat the paragraph twice: Conservative treatment Preoperative MRI in a 74-year-old man revealed penetration of the rectal front wall by the large tumor including the full thickness of the rectal layers and invasion of Denonvilliers' fascia (DF) at the level of the seminal vesicle (SV) (Fig3. 1–2). Chest X-ray, abdominal and head CT scans showed no distant metastases. The patient refused preoperative neoadjuvant therapy for heart disease. Abdominal swelling and pain, fever and abnormal characteristics of intrapelvic drainage tube with an average 15-30ml feces appeared on Pod 3. But abdominal pain intensified and new symptoms of left scrotal swelling and urine turbidity emerged on Pod 4 (Fig3. 3). Lavaging from an intrapelvic drainage tube with 250/500 ml normal saline flush with negative pressure, anti-inflammation with broad-spectrum antibiotics (Metronidazole) once per day and enteral nutrition, which feasible for advanced ileostomy to be performed on operation, were administered to improve symptoms, while moxifloxacin was added once per day due to unimproved urinary tract symptoms, eg left scrotal edema, pneumaturia emerging on Pod 12 and fecaluria on Pod 14, respectively. Transabdominal sinus radiography identified rectal AL but not urethral leakage (Fig3. 4). RSVF was identified by CT showing that contrast agent retrogradely entering the ductus deferens around the entrance to the epididymis (Fig3. 5) and air bubbles squeezing in SVs and bladder via the sinus secondary to AL (Fig3. 6).

Thank you for the careful check. We are sorry for the mistakes. We recheck the manuscript and delete duplicate statements.

Delete duplicate statements:

Preoperative MRI in a 74-year-old man revealed penetration of the rectal front wall by the large tumor including the full thickness of the rectal layers and invasion of Denonvilliers' fascia (DF) at the level of the seminal vesicle (SV) (Fig3. 1 – 2). Chest X-Ray Computed, abdominal and head CT scans showed no distant metastases. The patient refused preoperative neoadjuvant therapy for heart disease. Abdominal swelling and pain, fever and abnormal characteristics of intrapelvic drainage tube with an average 15-30ml feces appeared on Pod 3. But abdominal pain intensified and new symptoms of left scrotal swelling and urine turbidity emerged on Pod 4 (Fig3. 3). Lavaging from an intrapelvic drainage tube with 250/500 ml normal saline flush with negative pressure, anti-inflammation with broad-spectrum antibiotics (Metronidazole)

once per day and enteral nutrition, which feasible for advanced ileostomy to be performed on operation, were administered to improve symptoms, while moxifloxacin was added once per day due to unimproved urinary tract symptoms, e.g. left scrotal edema, pneumaturia emerging on Pod 12 and fecaluria on Pod 14, respectively. Transabdominal sinus radiography identified rectal AL but not urethral leakage (Fig3. 4). RSVF was identified by CT showing that contrast agent retrogradely entering the ductus deferens around the entrance to the epididymis (Fig3. 5) and air bubbles squeezing in SVs and bladder via the sinus secondary to AL (Fig3. 6).  
Conservative treatment

The limitations are that with the cases provided, it is not possible to give a therapeutic regimen to be followed in this complication. Thank you

Thank you for the careful check. This is an important question. Because this kind of complication is rare, individualized treatment and other reasons, just as the limitations proposed by experts, there is no fixed treatment plan to follow, but we summarize the experience, and put forward opinions for readers to reference. We re-analyze and modify the original text and explain it as follows:

In total, 4 of the 16 were cured by conservative therapy, 4 cases improved or were healed by conservative therapy plus abscess or fistula incision and drainage, 9 cases were remedied by colostomy or ileostomy after failed treatment (A temporary protective ileostomy had been performed during the first operation in case 3), 2 cases with severe infection underwent urinary and fecal diversions combined with long-term postoperative anti-infection therapy, and in 1 case treatment was unclear.

Add this sentence at the end of the main discussion

The limitations are that with the cases provided, it is not possible to give a therapeutic regimen to be followed in this complication. Therefore, individualized treatment of RSVF is necessary.

## 4 REVISE THE MANUSCRIPT

### 4.1 Guidelines and Requirements for Manuscript Revision and the Format for

**Manuscript Revision:** Please visit: <https://www.wjgnet.com/bpg/GerInfo/291>.

We have read the revised manuscript guide and amended as required.

**4.2 Preparatory work for revising your manuscript:** (1) [Original articles](#); (2) [Review articles](#); and (3) [Case report articles](#).

We have prepared these three parts as required.

**4.3 Editorial office's comments:** Authors must revise the manuscript according to the Editorial Office's comments and suggestions, which are listed below:

**(1) Science editor:** 1 Scientific quality: The manuscript describes a case report of the rectoseminal vesicle fistula after radical operation for rectal cancer. The topic is within the scope of the WJCC. (1) Classification: Grade C;

We are very exciting to get the positive comment from the expert in this field. Thank you very much.

(2) Summary of the Peer-Review Report: The article is interesting because of the exceptional nature of this complication and the treatment used in 4 + 8 cases. The questions raised by the reviewers should be answered; and (3) Format: There are 1 table and 4 figures. A total of 36 references are cited, including 6 references published in the last 3 years. There are no self-citations. 2 Language evaluation: Classification: Grade A. A language editing certificate issued by IseedEditing was provided. 3 Academic norms and rules: The authors provided the signed Conflict-of-Interest Disclosure Form and Copyright License Agreement, and the written informed consent. No academic misconduct was found in the CrossCheck detection and Bing search. 4 Supplementary comments: This is an unsolicited manuscript. No financial support was obtained for the study. The topic has not previously been published in the WJCC. 5 Issues raised: (1) The authors did not provide original pictures. Please provide the original figure documents. Please prepare and arrange the figures using PowerPoint to ensure that all graphs or arrows or text portions can be reprocessed by the editor;

Thanks to the editor for raising these issues we overlooked. We provided the original pictures and used PowerPoint to prepare and arrange the graphics to ensure that the editor can reprocess them.

57013-Figures.ppt

(3) PMID and DOI numbers are missing in the reference list. Please provide the PubMed numbers and DOI citation numbers to the reference list and list all authors of the references. Please revise throughout; and

Thank you for the question, we have added as required in the reference list.

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(4) The “Case Presentation” section was not written according to the Guidelines for Manuscript Preparation. Please re-write the “Case Presentation” section, and add the “FINAL DIAGNOSIS”, “TREATMENT”, and “OUTCOME AND FOLLOW-UP” sections to the main text, according to the Guidelines and Requirements for Manuscript Revision. 6 Re-Review: Required. 7 Recommendation: Conditional acceptance.

Thank you for the editor's guidance on the writing format and process. We have revised all as required. If there are any imperfections, we hope to have the opportunity to revise it again. Thank you. Please review the text.

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Thank you for the Editorial office director's guidance.

(3) **Company editor-in-chief:** I have reviewed the Peer-Review Report, full text of the manuscript, and the relevant ethics documents, all of which have met the basic publishing

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Thank you.

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Thank you for the editorial guidance, we have added it as required. All authors with references were added.

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