27 September 2020

Lian-Sheng Ma

*World Journal of Clinical Cases*

Dear Prof. Lian-Sheng Ma,

We wish to resubmit the manuscript titled "Endoscopic fenestration in the diagnosis and treatment of delayed anastomotic submucosal abscess: A case report and review of the literature". The manuscript ID is 57240.

We would like to thank you and the reviewers for the positive evaluation of our manuscript. We have carefully read all comments and suggestions and have revised the manuscript accordingly. The constructive suggestions provided to us have helped improve both the quality and clarity of the manuscript. We hope that the revised paper is now acceptable for publication in ***World Journal of Clinical Cases***. Our point by point responses to the reviewers' comments are appended below.

Thank you for your consideration. I look forward to hearing from you.

Yours sincerely,

Bao-Zhen Zhang, Jin-Tao Guo

guojt@sj-hospital.org;

**Science editor:**

1.The authors did not provide the approved grant application form(s). Please upload the approved grant application form(s) or funding agency copy of any

approval document(s);

Answer:

Thank you. We have uploaded related funding documents.

2.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;

Answer:

Thank you. We have uploaded and embedded all original figures into PowerPoint.

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.

Answer:

Thank you. We have listed the PubMed numbers and DOI citation numbers in the references and listed all authors.

**Reviewer #1:**

1.Case report: the description of the case can be shortened considerably and sub-headings like chief complaints, h/o present illness, past illness, family history etc can be concised to the case description.

Answer:

Thank you for your suggestion. We have modified the medical history in accordance with the Guidelines for Authors of the *World Journal of Clinical Cases*.

2.If the authors suspected a submucosal tumor, and the EUS showed an

anechoic/hypoechoic lesion- why did the authors not do an FNA/core biopsy rather than attempting a fenestration

Answer:

Thank you for your suggestion. The lesion was small, about 1.5 cm in diameter. Pathological tissue specimen obtained by FNA or core biopsy is limited, and the price of FNA is much higher than that of endoscopic treatment. Therefore, endoscopic treatment is more in line with health economics.

3.If the lesion was arising from the muscularis propria which did the authors attempt a fenestration- where they planning on a full thickness resection initially?

Answer:

Thank you for your suggestion. During the incision, the mass surface was soft, and on opening the capsule wall, we observed oozing of yellow pus. The purpose of our treatment was to fully drain the abscess using endoscopy rather than to remove the entire lesion; a full thickness resection was not necessary.

4.technically a fenestration is when the abscess is left open- the authors closed this with clips- that would not be fenestration

Answer:

Thank you for your suggestion. The purpose of fenestration was to drain the pus. After the drainage was entirely cleaned from the area, clips were used to prevent postoperative complications such as bleeding and perforation. Moreover, preoperative pelvic-enhanced CT indicated no thickening or abnormal enhancement at the anastomotic site. Therefore, it was not necessary to leave the lesion open after the abscess had been removed sufficiently.

5.Did the authors culture the contents to determine if they truly were infective?

Answer:

Thank you for your suggestion. In principle, an abscess needs to be cultured; however, our patient's lesion was at the rectum and highly susceptible to contamination by intestinal faeces and flora. Therefore, we did not culture the abscess at that time.

**Reviewer #2:**

I wanted to know at the time of diagnosis of rectal cancer whether MRI was done or not. What was the status of margins and lymph nodes at imaging and pathology.

Answer:

Thank you for your suggestion. At the time of the diagnosis of rectal cancer, an MRI was not completed for auxiliary diagnosis. At the time of laparoscopic radical resection of rectal cancer, the pathologic description of the lesion was as follows:

A (rectal) adenocarcinoma (moderately differentiated) was found to be infiltrating the entire intestinal wall and extra-membranous adipose tissue. The size of the mass was 3.0 × 2.5 cm. Part of the cancer tissue infiltrated the nerve , while no cancer tissue infiltrated the vessels.

A) Circumferential margin did not show cancerous tissue.

B) No cancerous metastasis was found in 12 mesenteric lymph nodes (0.1-0.8 cm).

C) There was no cancerous tissue in the distal margin (2.5*2.0*0.5 cm).

**Reviewer #3:**

Dear Authors, the manuscript entitled "Endoscopic fenestration in the diagnosis and treatment of delayed anastomotic submucosal abscess: A case

report and review of the literature", by Bao-Zhen Zhang et al from Shenjing Hospital of China, is an interesting report on a rare case of delayed anastomotic submucosal abscess after laparoscopic resection of a rectal cancer. The case is well documented and has clinical relevance as an example of mini-invasive treatment of an anastomotic abscess. Unfortunately the English language is rather poor and some times misleading, and I think it should be totally revised. Moreover, it is not discussed if the patient had a protective ileostomy after anterior rectal resection. I think this issue should also be addressed.

Answer:

Thank you for your suggestion. We used the services of Editage to edit the manuscript for language, word usage, and flow. We have also attached a language certification for our revised manuscript. Our patient did not have a protective ileostomy after the anterior rectal resection.