1. Past history of laser ablation to be clarified - when? Whether a lesion was present?

At the patient's consultation office visit he commented on undergoing laser ablation of a hemorrhoid approximately 10 years prior to that visit. There is no procedural note available to determine which column was laser ablated. Though no note exists in the EMR for our healthcare system or those that communicate with our healthcare system, he does not have previous pathology reports available that would correlate to biopsy of a previous lesion.

2. Was the abnormal pathology traced to the corresponding column excised?

The procedure at which the adenocarcinoma was identified was a 3 column excision. The specimen from which the adenocarcinoma was identified was the left lateral hemorrhoid, which was found to have "invasive moderately-to-poorly differentiated adenocarcinoma arising in hemorrhoidal tissue". Since there is no procedure not from the ablation we cannot be sure if it was the same column.

3. How exactly was the re excision carried out ? The description "..full-thickness transanal excision with 2 cm lateral margins and a 4-5 cm extension into the distal rectum" does not mention about the depth of excision. Was a frozen section examination planned at the time of re excision?

Excision was carried out with a wide margin from the previous scar (at least 2 cm in either direction). The cautery mark was extended at least 3 cm on the perianal skin and at least 4-5 cm into the anal canal and distal rectum. An elliptical incision was made at the skin side and this was carried down into the ischioanal fat. Dissection was continued proximally and laterally just over, and including, some strands of the internal sphincter muscle. Dissection in this plane was carried all the way down to about 4-5 cm proximal to the anal verge in the distal rectum, completing a full-thickness excision. A 2-0 Vicryl suture was then placed at the apex and the specimen was then completely excised. The specimen was marked it with a stitch at the proximal and anterior aspect. The thickness of the specimen measured 1.7cm. The specimen was sent for permanent examination; frozen section was not planned or carried out. The site was closed with a 2-0 Vicryl suture to run the wound from the proximal to distal aspect.

4. Whether the background Diabetes / age had any influence on poor wound healing in addition to the local factors?

Albumin was 4.4 at the time of the initial surgery. Hemoglobin A1c was 6.3 at the time of the initial surgery.

5. The figure has actually 2 sets of photo-micrographs and accordingly can be individually labeled for better information

The figures have been re-labeled.

6. The figure legend does not include the details of magnification, stain, etc

This has been addressed in the figure legends.

7. How to differentiate whether the lesion is a deposit / primary / implanted on histology?

The patient underwent a full staging workup including colonoscopy, CT chest/abdomen/pelvis, and endorectal ultrasound. The assumption is that it is a primary tumor and not a tumor deposit or metastases from an unknown primary site.