

Reviewer1

The framework of writing is intact. However, English use still requires re-checking (e.g. 402 cases series, line 2 and ---). Some doubts require clarification:

1. The conclusion in Abstract (line 27-34) is too long. It had better be simplified.

We thank for your comment. We have rewritten this part in revised manuscript and highlighted in yellow.

2. This treatment regimen is for temporary use before definite internal fixation is performed. In Highlights, long-term safety (line 49) is suggested to follow. What do you mean?

We thank for your comment. We have deleted this sentence in terms of inappropriate description in the revised manuscript.

3. In Results, description of demography (line 166-171) had better be used with a ratio. The exact number makes confusing.

We thank for your comment. We have corrected them in Results and highlighted in yellow in the revised manuscript.

4. Line 171-173, what do you mean?

We thank for your comment. We have replaced the sentence by “With the exception of two patients, external traction fixation was removed in all other patients one day before definitive surgery.” in the revised manuscript.

5. Line 189, discharge is generally due to too small incision wound for pin insertion with poor drainage. With a short period of pin insertion in this study, the causes of discharge problems should be searched with discussion.

We thank for your comment. We have discussed this issue in discussion as follow: “Meanwhile, too small incision wound for pin insertion may led to poor drainage, which should pay attention when insert the pin. Special caution must be exercised when the procedure is performed for patients with diabetes patients owing to the increased risk of adverse outcomes” and highlighted in yellow in the revised manuscript.

6. In Discussion, the authors should search for some prior articles about the safe periods of primary external fixation and secondary internal fixation. The internal fixation includes an intramedullary nail or plate. If the secondary internal fixation is performed beyond the safe period, how to handle to prevent deep infection?

We thank for your comment. We have discussed this issue in discussion as follow: “The pin insertion and postoperative complications, especially postoperative infection, are another concern of orthopedic surgeons. The researchers tended to keep the first stage treatment for 14 or 28 days[24]. Beyond this period the risk of infection may need to be reassessed or an external fixator may be used as final treatment. It is recommended that the interval from stage 1 to stage 2 be no more than 14 or 9 days[25, 26]. In any case, evaluating the timing and interval of staged treatment requires a combination of individual patients and dynamically observed indicators of infection” and highlighted in yellow in the revised manuscript.

7. In Table 1, the orientation of pin insertion is doubtful. The principle of pin insertion is from a dangerous zone to a safe zone for prevention of damage by pin deviation. Therefore, at the femur supracondyle, the starting point is from the lateral aspect (for the common peroneal nerve). Similarly, at the whole tibia (for nerves and vessels), at the calcaneus (for the posterior tibial artery). Explanation is necessary in Discussion section.

We thank for your comment. The pin insertion of femur supracondyle may remain controversial nowadays because we found some research recommend that “the pin should be placed on the medial femoral cortex and ‘walked’ anteriorly and posteriorly to ensure placement in the center of the bone” (cited from *DeFroda SF, Gil JA, Born CT. Indications and anatomic landmarks for the application of lower extremity traction: a review. Eur J Trauma Emerg Surg. 2016;42(6):695-700. doi:10.1007/s00068-016-0712-3*). The other research approved that “Steinman pin was drilled from lateral to medial exiting the medial skin.” (cited from *Kwon JY JC. Lateral femoral traction pin entry: risk to the femoral artery and other medial neurovascular structures. J Orthop Surg Res 2010;5*). We agree that principle of pin insertion is from a dangerous zone to a safe zone for prevention of damage by pin deviation. However, due to the controversial description and less related to our aim, we put this table to supplementary material for reference. More discussion of the anatomic landmarks for the application of lower extremity traction may require a review for better explanation.

Editorial Office’s comments: 5 Issues raised: (1) The signed Copyright License Agreement, and the Institutional Review Board Approval Form were not provided. Please provide those two documents;

We thank for your comment. We had provided two documents in revised manuscript.

(2) The “Author Contributions” section is missing. Please provide the author contributions;

We thank for your comment. “Author Contributions” section was provided in revised manuscript.

(3) 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;

We thank for your comment. PowerPoint was provided in revised manuscript.

(4) 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;

We thank for your comment. Reference list was re-checked in revised manuscript

(5) The “Article Highlights” section is missing. Please add the “Article Highlights” section at the end of the main text.

We thank for your comment. “Article Highlights” section was provided in revised manuscript.