Detailed Responses to Reviewers

Dear Editor,

We would like to thank you and the reviewers for the detailed and suggestions on our manuscript. The reviews have raised some excellent questions, and we sought to address each issue in detail in this letter and in the attached revised manuscript. You will find the reviewer's comments in *italic*, followed by our detailed response. The original text is shown in blue, and the revised or added text is shown in red.

We hope that you and the reviewers will find our responses to be adequate. We thank you again for your time and effort spent reading and commenting on our manuscript.

Regards,

Hyun Ho Kong

January 12, 2021

1) *Line 87-88: "around 3 months before." This description is very unclear and a bit confusing. I suggest replacing with "How many days after first operation".*

: Following your advice, we have revised the sentence more clearly.

[Line 86-88]

A 58-year-old male was referred to the department of rehabilitation medicine for an electromyography (EMG) study for bilateral foot drop that occurred around 3 months before.

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A 58-year-old male was referred to the department of rehabilitation medicine for electromyography (EMG) study for symptoms of bilateral foot drop that appeared 25 days after the first biliary surgery.

2) *It would be good to also include a flowchart within the text addressing the important chronological presentation of the patient to the readers.*

: Following your opinion, we have added a flowchart for the chronological presentation. And we have modified the related text and added a figure legend.

[Line 162-163]

The overall recruit pattern was also improved in the needle EMG.

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The overall recruit pattern was also improved in the needle EMG. The timeline of this case is shown in Figure 2.

[Figure Legend]

Figure 2 Case timeline. BMI: Body mass index; OP: Operation; CBD: Common bile duct; DF: Dorsiflexor; EMG: Electromyography; MRI: Magnetic resonance imaging; USG: Ultrasonography; CPN: Common peroneal neuropathy.

3) *Blood tests were conducted to detect diabetes mellitus, thyroid dysfunction, vitamin B12 deficiency, or folate deficiency with negative results. Malnutrition, vitamin/mineral and*

certain element deficiencies seems to be the etiology. Did you check thiamine as possible deficiency may be the cause? Expand discussion with your experience in the dietary modifications.

: We also tested vitamin B1 (thiamine) and B6. Both vitamin B1 (6.3 μg/dL, normal range 2.0–7.2 μg/dL) and vitamin B6 (45.1 μg/L, normal range 5.0–50.0 μg/L) were in the normal range. This blood test result was also added to the text. In addition, we also added a discussion about the possibility of paralysis due to a deficiency of micronutrients such as vitamins.

[Line 132-134]

In addition, blood tests were conducted to detect diabetes mellitus, thyroid dysfunction, vitamin B12 deficiency, or folate deficiency, which may cause non-compressive peroneal neuropathy; however, all test results were normal.

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In addition, blood tests were conducted to detect diabetes mellitus, thyroid dysfunction, vitamin (B1, B6, and B12) deficiency, or folate deficiency, which may cause non-compressive peroneal neuropathy; however, all test results were normal.

[Line 191-196]

If a patient experiences foot drop symptoms, not only peroneal neuropathy but also sciatic neuropathy, lumbosacral plexopathy, L5 radiculopathy and peripheral polyneuropathy should be included in the list of differential diagnoses. Hereditary neuropathy with liability to pressure palsy, an autosomal dominant disease, should be differentiated especially in younger patients with symptoms of paralysis after trivial trauma or weight loss.

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If a patient experiences foot drop symptoms, not only peroneal neuropathy but also sciatic neuropathy, lumbosacral plexopathy, L5 radiculopathy and peripheral polyneuropathy should be included in the list of differential diagnoses. In particular, a deficiency of vitamins (B1, B6, B9, and B12) and minerals can cause peripheral polyneuropathy, and dietary modifications such as supplementation of insufficient

nutrients can help recovery. However, it is difficult to suppose that the deficiency of micronutrients was the cause of paralysis in this patient because the blood test for micronutrients was in the normal range. And the patient also showed abnormal findings with a pattern of focal mononeuropathy in the EMG study, unlike polyneuropathy which is generally seen in nutritional neuropathy. In addition, hereditary neuropathy with liability to pressure palsy, an autosomal dominant disease, should be differentiated especially in younger patients with symptoms of paralysis after trivial trauma or weight loss.