Dear editor

Thank you for your valuable advice and reviewers. We have summarized the answers to the contents of the comments you pointed out. Changes in the text are indicated in red text.

Reviewer #1

1. Is this CNF, the same as Ludwig's angina? If so pls add this and if not, still add how it is different.

-> Ludwig Angina is bilateral inflammation that invades the submandibular area. On facial enhanced CT, this patient showed craniofacial necrotizing fasciitis in which inflammation spreads through the masseter and temporal fascia. In addition, there were no symptoms such as dysphagia, tongue edema, and limitation of cervical movement, which are common with Ludwig Angina. In addition, the patient had no evidence of dental procedures or odontogenic infection, a common cause of Ludwig Angina.

2. The patients index infection site was lung or kidney? Cant be both. Potentially kidney?

-> In our opinion, the primary infection site is presumed to be the kidney because the patient's clinical symptoms had improved after drainage through the percutaneous catheter. In addition, the patient's renal abscess was about 3 cm in diameter, so aspiration was initially considered. However, after consulting with the department of the infectious internal medicine, the insertion of the PCD(Percutaneous catheter drainage) was recommended and implemented instead of aspiration.

3. Mostly Klebsiella dont produce gas. SOmetimes it does! Sometimes there is polymicrobial sepsis and the micro lab may not grow every time all the organisms. Comment on this.

-> The possibility of polymicrobial infection is lowered because only one strain of Klebsiella pneumoniae was consistently detected in all samples of the patient's pus of the wound site, sputum, and blood. Therefore, the possibility of sepsis caused by monomicrobial infection seems to be higher.

4. Immunosupporession? Uncontrolled DM?

-> The patient did not have a disease that could cause immunosuppression and was in an uncontrolled DM state with an HbA1C of 17.1 at the time of admission.

5. Agree with learning lessons as narrated.

-> Thanks for agreement.

6. Too many numeric of lab results. Possible to reduce and omit and mention some as "normal"

-> Normal numerical values of each result value were deleted, and items with normal numerical values were omitted.

7. The second picture after 6 months is not needed, readers will trust that pt recovered without residual disabilty. Is ok. Can omit it.

-> Figures 1 and 9 are omitted

Reviewer #2

1. Please supplement the patient's creatine kinase, creatine kinase isoenzyme and myoglobin indexes, which are of great significance for diagnosis.

-> It is known that such markers have clinical value, but the diagnosis was made early with imaging tests and other inflammation markers, so it was not performed separately. We confirmed an increase in procalcitonin, a promising marker of bacterial infection instead of creatine kinase, creatine kinase isoenzyme and myoglobin. Since significant elevation of procalcitonin level does not increase in viral or nonspecific inflammation, it can be inferred that this patient is in a state of severe bacterial infection.

2. Figure 1 and Figure 9 are suggested to be removed to protect patient privacy.

-> Figures 1 and 9 are omitted.

I thank you in advance for your concern

Sincerely yours

Hwan Jun Choi, M.D., PhD
Department of Plastic and Reconstructive Surgery
Soonchunhyang University Cheonan Hospital