

**General response:** We sincerely thank the Editor and all the Reviewers for your valuable feedback, which we have used to improve the quality of our manuscript. The Reviewers' comments are written in italics below, and the specific concerns have been numbered. Our responses are written in normal font, and the changes/additions to the text are shown in blue text.

*Reviewer #1:*

*Scientific Quality: Grade D (Fair)*

*Language Quality: Grade C (A great deal of language polishing)*

*Conclusion: Major revision*

*Specific Comments to Authors: The authors presented a case of peritonitis due to seminal vesicle abscess. The patient was successfully circumvented the worst scenario. The labor should be admired regarding the patient care. Results of blood examination should be presented in tables. Clinical course was not presented after the surgery. As the authors mentioned, seminal vesicle abscess is a rare condition. How would the authors speculate its cause? The patient underwent surgical treatment of benign prostatic hyperplasia. He suffered difficulty urinating, and had a long-term indwelling urinary catheter. Were there any possibilities that this past history affected the disease? Diagnosis of seminal vesicle abscess is crucial in the management of the condition. Figure 1 shows slight pelvis ascites. Where is the finding suggesting seminal vesicle abscess?*

**Response:** Thank you for your approval of this article. The blood test results have been sorted and listed in Table 1:

Date	Leukocytes ( $\times 10^9/L$ )	Creatinine ( $\mu\text{mol/L}$ )	Albumin (g/L)	Prothrombin time (s)	C-reactive protein (mg/L)
DBO5	13	92	34.3	13.1	151.77
DBO4	11.62	81	31.5	15.7	157.74
DBO2	22.41	157	30.1	17.9	227.71
DBO1	34.67	153	18.2	18.6	239.87
OD	23.85	173	25.0	17.7	177.34
POD1	20.35	158	28.4	16.6	204.14
POD2	14.96	128	34.2	16.0	177.26
POD3	11.29	109	34.4	15.5	141.1
POD4	11.41	104	35.6	14.1	99.55
POD6	16.98	88	35.3	14.2	57.6
POD8	15.39	85	33.5	15.0	37.0
POD10	13.07	91	33.5	14.4	99.3
POD12	7.3	87	30.2	14.3	118.73
POD15	6.78	78	30.6	14.1	66.02

**Table 1** Changing trend in the patient's laboratory indices. Leukocytes ( $\times 10^9/L$ ); Creatinine ( $\mu\text{mol/L}$ ); Albumin (g/L); Prothrombin time (s); C-reactive protein (mg/L). DBO: days before operation (DBO5 refers to the day of admission); OD: operation day, referring to the date of exploratory laparotomy; POD: postoperative days (POD15 refers to the discharge date).

The relevant disease course after surgery has been added to the abstract (**Page 1**) and the 'Treatment' section (**Page 5**) as follows:

**Page 1:** The operations were successful. After the operation, anti-infection, anti-shock and nutritional support treatment were continued and various laboratory indicators were regularly reviewed. The patient was discharged from the hospital after recovery. This disease is a challenge for the clinician because of the unusual spreading path of the abscess.

**Page 5:** After the operation, the patient was transferred to the intensive care unit due to his critical condition. He fasted and underwent ECG monitoring, continued anti-infection, anti-shock and nutritional support treatment. The internal environment and water electrolyte balance was maintained. The function of various organs was monitored. Plasma was infused to achieve coagulation, and wound dressings were changed regularly. Various laboratory indicators were routinely checked. On the 1st day after the operation, the patient had dyspnea and atrial fibrillation with a fast ventricular rate after taking off the line. He received high flow oxygen inhalation and his heart rate was regulated with amiodarone. Treatment to resolve abdominal distension and promote gastrointestinal motility was performed. The pus culture showed *Klebsiella pneumoniae* infection. A combination of meropenem and linezolid was administered, and the patient's symptoms and signs were gradually resolved. On the 3rd day after the operation, the patient's heart rate returned to normal, oxygen saturation was maintained with low-flow oxygen inhalation, the infection was eradicated, and abdominal distension was relieved. Later, the patient returned to general surgery for further treatment. On the 4th day after the operation, a liquid diet was initiated. The amount of intravenous fluid replacement was reduced and he was encouraged to get out of bed to prevent embolization. On the 7th day after the operation, abdominal distension recurred. He continued to fast, and the wound suture was removed. On the 10th day after the operation, the patient complained of hunger but abdominal distension was relieved. Abdominal CT showed less abdominal inflammation than before (Figure 2b, f). Three days later, the patient's diet was changed to a semiliquid diet. Two days later, the patient did not complain of any special discomfort, however his body temperature returned to normal, and he was allowed to resume a normal diet. The other catheter was replaced, and the patient was discharged.

The causes and risk factors of seminal vesicle abscess in this case have been analyzed, and the findings have been added to the first paragraph of the 'Discussion' section (**Page 6**) as follows:

In our case, this patient underwent surgical treatment of benign prostatic hyperplasia. He suffered difficulty urinating and had a long-term indwelling urinary catheter. We speculate that his previous medical history is an important risk factor for SVA.

We have also modified and improved the figures in this article. In Figure 1, four MRI pictures were placed to show the T1- and T2-weighted images of the seminal

vesicle abscess and pelvic abscess, respectively. Figure 2 was changed to CT contrast images of the patient's pelvic cavity throughout the diagnosis and treatment processes. In Figure 2, the locations of the primary and secondary lesions can be conveniently viewed, and the clinical course of the patient from onset to outcome can be better understood. We used arrowheads to indicate the primary lesions in this figure, and the arrows indicate the secondary lesion.

*Reviewer #2:*

*Scientific Quality: Grade C (Good)*

*Language Quality: Grade B (Minor language polishing)*

*Conclusion: Minor revision*

*Specific Comments to Authors: 1. The entire manuscript needs revision for the long sentences. These should be edited to improve understandability of the provided text. 2. Table should be provided with a header. 3. References list is too lengthy, revise and omit unnecessary references.*

**Response:** We apologize for the spelling and grammar errors in our manuscript. We have sent the manuscript back to AJE (<https://www.aje.cn/>) for further polishing and revision. We will provide an English Editing Certificate during re-submission of our manuscript. Headers have been added to all the tables and figures as follows:

Figure 1. MRI results of the patient after admission.

Figure 2. CT results of the patient throughout the diagnosis and treatment processes.

Figure 3. Intraoperative and postoperative pathological films.

Figure 4. Three-dimensional CT reconstruction showing the primary and secondary abscesses.

Figure 5. CT sagittal view of the relationship between the secondary focus and the pelvis and abdominal cavity.

Table 1. Change trend of patient's laboratory indexes.

Table 2. Summary of literature on primary seminal vesicle abscess treated with surgery since 2004.

Additionally, the number of references in our manuscript has been reduced from 35 to 30. The reference numbering in the article has been re-ordered accordingly.

**Response:** Further, we have corrected some errors in words, grammar and logic. These corrections mainly include the following (the page numbers indicate the locations of the text in the manuscript):

**Page 4:** The discharge diagnoses were 1. Septic shock; 2. ADP, acute extraserosus suppurative appendicitis; 3. Left SVA; 4. pelvic abscess; and 5. hypertension grade 3 (high risk).

**Page 5:** After discharge, the patient began to undergo follow-up reviews regularly for a total of 1 year. These two inflammatory foci gradually controlled and narrowed after treatment and outpatient and emergency follow-up (Figure 2c-d, g-h).

We have also made other modifications that aren't mentioned here (e.g., we

replaced some words with synonyms and enhanced the sentence structure, with the help of AJE editors).

Thank you again for your critiques of this article and suggested corrections to the text. We hope that you will be satisfied with our responses. If you have any further suggestions for modifying and/or re-writing the manuscript, please do not hesitate to contact us. We look forward to your reply.