We appreciate the reviewer for the helpful comments on the inflammatory bowel disease (IBD) that we are not familiar.

It's a pity that our laboratory is unable to detect the fecal calprotectin, so we use blood CRP and fecal occult blood test for alternative to speculate the intestinal lesions.

Regarding gastrointestinal irAEs induced by anti-PD-1/PD-L1 antibodies, colitis occurs in up to 5% of patients, but generally presents as diarrhea and less often as abdominal pain and hematochezia. The main chief of our patient was abdominal pain, which aggravated after meals, and accompany with increased CRP and positive occult blood in stool, edema and thickening of small intestinal wall by CT scan, no remarkable findings by electronic colonoscopy, intestinal obstruction， postoperative histopathological staining showed infiltration of lymphocytes, plasma cells, and neutrophils, along with simple ulcers in the affected bowel loops, all of which were consistent with IBD, especially Crohn's disease (CD), which need further follow up to confirm.

Concerning mesalamine, we consulted his surgeon. The surgeon told us that his resected terminal ileum was about 5cm, and there was transmural inflammation at the stenosis of intestinal canal. Because of his large fluctuation in blood glucose, he was suggested to use immune modulators such as methotrexate or biological agents such as adalimumab for his CD, but due to the fear of the serious adverse reactions induced by earlier treatment of nasopharyngeal carcinoma by chemotherapy and PDL1 inhibitor teriprizumab, he refused these medications. At last, he was administered mesalazine 4g/d. The patient was discharged on oral mesalazine sustained-release granules with a dosage of 1 g quarterindie for 8 weeks and then maintained at 1g twice daily to now.

We asked for professional people for language polishing and wish to be easier for reading.