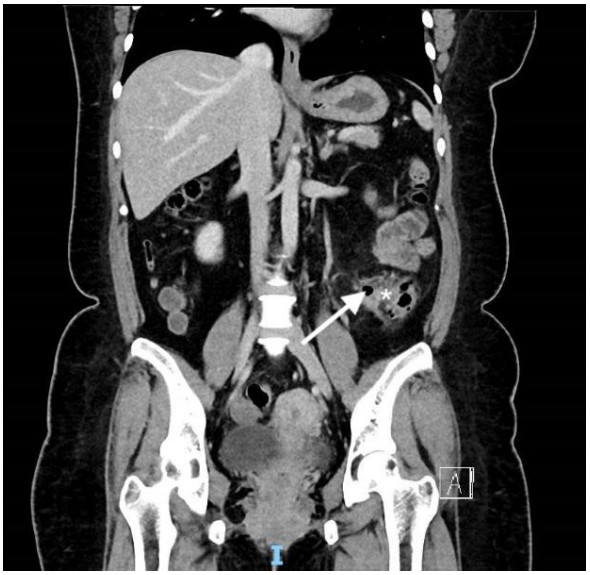
Dear Reviewers,

RE: Revisions in Response to Review of Manuscript

Thank you for giving us the opportunity to revise our manuscript. We believe that the changes we have made have significantly improved the quality and clarity of the paper, and we hope that you and the reviewers will find the revised version to be acceptable for publication in the World Journal of Clinical Cases.

Please find attached the revised version of the manuscript, along with a detailed response to the reviewers' comments. We have addressed each comment individually and explained how we have revised the manuscript to address the concerns and suggestions raised by the reviewers.

Comment	**Changes made/ Response**
Reviewer 1	
The description of the clinical features of the patients was not sufficiently detailed. A physical examination of the patient only described tenderness on the left flank with no guarding. A more detailed physical examination is required to rule out other diseases causing the pain.	*Otherwise, physical examination was unremarkable. There were no signs of chronic liver disease – no jaundice, caput medusae, scleral icterus, Dupuytren contractures, clubbing, hepatic asterixis, gynaecomastia, spider naevi, shifting dullness or pedal oedema. There are no signs of anaemia – no conjunctival pallor, no palmar crease pallor. There were no signs pointing to any kidney pathology – there were no renal bruits and kidneys were non-ballotable. There was no hepatomegaly or splenomegaly. Bowel sounds were active.*
In addition, the results of the child's treatment can be described more specifically.	*It was managed conservatively with the following course of antibiotics for 5 days – IV ceftriaxone 2g once a day, and IV metronidazole 500 mg thrice a day. Subsequently, the patient was started on oral co-amoxiclav for a total of 4 weeks.*
The author's article states that the patient had a colonoscopy at the 6-week follow-up. Why don't patients get a colonoscopy before treatment to compare and make the results more accurate?	ESGE Recommends scopes at 4 - 6 weeks post-acute diverticulitis to rule out the 4% chance of malignancy. In the case of a perforated acute diverticulitis, an earlier scope is contraindicated. So, we routinely scope acute diverticulitis, especially perforated acute diverticulitis only at or after 6 weeks.

Please label Figure 1 more clearly	 Figure 1: CT Abdomen pelvis coronal cut representing a sealed perforation. The arrow (→) represents an air bubble extraluminal air pocket, showing a pericolic abscess. The asterisk (*) represents the sigmoid colon with signs of pericolonic fat stranding and peritoneal thickening. *Note: We were unable to upload this directly into the portal
It is necessary for author to perform further language polishing that will ensure all grammatical, syntactical, formatting and other related errors be resolved, so that the revised manuscript will meet the publication requirement.	We have reread and addressed the possible errors in language. English is our first language, as well as our working language.
Reviewer 2	
The polyp has never been seen in the Computer Tomography? It will be interesting to have the report and images from the initial CT.	The “polyp” was not seen on the initial scan
The initial CT shows a Modified Hinchey Ib. Do the authors think the polyp represented the previous site of diverticular perforation? What perforation?	Yes, the histology and the location of the polyp in reference to the CT scan suggests that the “polyp” represents healing tissue i a sealed perforation of a sigmoid diverticulum.
Conclusion: It is too long; you can use this information in the discussion section.	*This case report displays the morphology of granulation tissue associated with healed diverticular perforations on colonoscopy. This serves to guide endoscopists during colonoscopy to help identify sites of recent perforations. Nonetheless, biopsies of lesions resembling our findings should still be taken, to rule out other pathologies. Tattoo placements may guide clinical treatment by allowing for more targeted colonic resections in the event of*

	recurrence of complicated diverticulitis at the same location. From our preliminary glimpse into the description of the morphology of healed perforated diverticulum, further studies may be conducted to broaden our understanding of the topic.
Reviewer 3	
The sentence " recurrence of diverticulitis is greater after an episode of uncomplicated diverticulitis at 24%, as opposed to after an episode of uncomplicated diverticulitis at 23.4%" may be false, and was it should be compared between complicated diverticulitis and uncomplicated ones?	*Recurrence of diverticulitis is greater after an episode of uncomplicated diverticulitis at 24%, as opposed to after an episode of complicated diverticulitis at 23.4%*

We appreciate the time and effort that the reviewers have put into evaluating our manuscript and providing valuable feedback. We believe that their comments have helped to strengthen the paper and make it more suitable for publication in the World Journal of Clinical Cases.

Sincerely,

Jacqueline Liew