Dear Editors:

On behalf of my co-authors, we are very grateful to you for giving us an opportunity to revise our manuscript. We appreciate you very much for your positive and constructive comments and suggestions on our manuscript entitled “Intestinal Tuberculosis with Small Bowel Stricture and Hemorrhage as the Predominant Manifestation: Case Reports and Review of the Literature”.

We have studied reviewer’s comments carefully and tried our best to revise our manuscript according to the comments. The following are the responses and revisions I have made in response to the reviewer’s questions and suggestions on an item-by-item basis. Thanks again to the hard work of the editor and reviewer!

Dear reviewer 1:

Comments to the Author:

1. Please elaborate “surgical treatment for tuberculosis of the cervical lymph nodes during adolescence.”

Response:

Thank you for the reminder and we have made corresponding changes. The revisions are listed as follows: “The patient had pulmonary tuberculosis during childhood, which was successfully treated. At the age of 24, the patient developed cervical lymph node tuberculosis and underwent surgical removal of the infected lymph nodes.”

2. “The small bowel endoscopy (SBE) revealed multiple ulcers and stenosis in the small intestine.”--- Was it duodenal? Or jejunal? Or ileal? Or any combination of the above?

Response:

We appreciate your kind reminder to avoid confusion among readers. The revisions are listed as follows: “The small bowel endoscopy (SBE) revealed multiple ulcers and stenosis in the middle and distal segments of the ileum.”

3. What about the distal gastrectomy? What did the pathology exam reveal?, and

provide the figures.

Response:

We gratefully appreciate your valuable suggestion. The patient underwent subtotal gastrectomy and local lymph node dissection. Pathological findings indicate advanced dysplasia with focal carcinoma in situ. The tumor is located within the mucosa and is a moderately differentiated adenocarcinoma. We have supplemented the information at the corresponding section of the article and provided pathological images.

4. The discussion needs to be more comprehensive, especially about diagnostic and therapeutic challenges.

Response:

We appreciate it very much for this good suggestion. In discussion, we further explored the current status of diagnosis and treatment for intestinal tuberculosis.

The revisions are listed as follows: “Intestinal tuberculosis is a disease known as the "great mimicker" due to its clinical symptoms, which can mimic various conditions. Currently, endoscopic combined biopsy histopathology is widely regarded as the most important approach for diagnosing intestinal tuberculosis. A meta-analysis study[18] revealed that the relative endoscopic features of intestinal tuberculosis include transverse ulcers, a patulous ileocecal valve, and cecal involvement. Pathology is considered the gold standard for diagnosing intestinal tuberculosis, although its diagnostic efficacy heavily relies on the quality of the endoscopic biopsy specimens. In comparison to the granulomas of Crohn's disease, tuberculous granulomas in the intestine are typically larger (>200 mm), confluent, and dense(>5/hpf) and are predominantly distributed in the submucosal layer. The presence of central caseous necrosis allows for a specific diagnosis of intestinal tuberculosis[19, 20]. However, due to the typical location of tuberculous granulomas in the submucosal layer, endoscopic biopsies are often sampled too superficially, resulting in a relatively low detection rate of caseous granulomas. Several studies[21, 22] have suggested that extensive sampling during endoscopy could be performed to improve the diagnostic rate of tuberculosis, albeit at the cost of an increased biopsy and processing time. In some cases of intestinal

tuberculosis, surgical intervention may be necessary to obtain sufficient pathological specimens for a definitive diagnosis. Additionally, interferon-gamma release assays (IGRAs) still hold significant value as a complementary method in the diagnosis of intestinal tuberculosis. A study indicated that the T-SPOT test has a sensitivity of 88% for diagnosing natural *Mycobacterium tuberculosis* infection, which is significantly greater than the 66% sensitivity of the tuberculin skin test[23]. In recent years, several studies [24, 25] have utilized the ratio of visceral fat to subcutaneous fat on CT scans to distinguish between Crohn's disease and intestinal tuberculosis. A cutoff value of 0.63 for the VF/SC ratio demonstrated a high sensitivity of 82% and specificity of 81% in distinguishing intestinal tuberculosis from Crohn's disease.

Traditional examinations such as histopathological examination, AFB, and *Mycobacterium tuberculosis* culture exhibit high specificity but low sensitivity[26]. Various novel molecular-based approaches, including IGRA, GeneXpert, PCR, and multiplex PCR, offer high sensitivity but limited specificity, resulting in limited clinical application[26]. In conclusion, an accurate diagnosis of intestinal tuberculosis requires a combination of patient history, physical examination, imaging examination, endoscopy, pathology, and the latest molecular detection methods.

…

Currently, conservative antituberculosis treatment is commonly used for patients with a confirmed diagnosis of SBT. A Cochrane meta-analysis of a randomized controlled trial (328 participants) revealed that patients treated with isoniazid, rifampicin, pyrazinamide, or ethambutol for a shorter duration (6 months) did not have a high rate of recurrence[27]. Additional observational data suggest that in most cases, six months of treatment is sufficient [28, 29]. If drug therapy fails to relieve symptoms or if complications such as intestinal obstruction occur, surgical treatment may be considered based on careful evaluation of the patient. In our reported cases, except for Patient 3 who underwent surgical resection of the intestinal tuberculosis lesion due to gastric malignancy, the main approach was drug therapy, and all the patients achieved satisfactory therapeutic effects.”

Reference:

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Choi HS, Hahm JS, Kim SY. Visceral fat as a useful parameter in the differential diagnosis of Crohn's disease and intestinal tuberculosis. *Intestinal research* 2014; **12**(1): 42-47 [PMID: 25349562 PMCID: PMC4204692 DOI: 10.5217/ir.2014.12.1.42]

25 Yadav DP, Madhusudhan KS, Kedia S, Sharma R, Pratap Mouli V, Bopanna S, Dhingra R, Pradhan R, Goyal S, Sreenivas V, Vikram NK, Makharia G, Ahuja V. Development and validation of visceral fat quantification as a surrogate marker for differentiation of Crohn's disease and intestinal tuberculosis. *Journal of gastroenterology and hepatology* 2017; **32**(2): 420-426 [PMID: 27532624 DOI: 10.1111/jgh.13535]

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Dear Science Editor:

1. Please provide the Language certificate. The English-language grammatical presentation needs to be improved to a certain extent. There are many errors in grammar and format, throughout the entire manuscript. Before final acceptance, the authors must provide the English Language Certificate issued by a professional English language editing company. Please visit the following website for the professional English language editing companies we recommend: https://www.wjgnet.com/bpg/gerinfo/240.

Response:

We are very grateful for your reminder. After revising our article based on the reviewers' comments, it has been submitted to a qualified language company for polishing. Please find the certificate attached.

2.Please provide the Figures cited in the original manuscript in the form of PPT. All text can be edited, including A,B, arrows, etc. With respect to the reference to the Figure, please verify if it is an original image created for the manuscript, if not, please provide the source of the picture and the proof that the Figure has been authorized by the previous publisher or copyright owner to allow it to be redistributed. All legends are incorrectly formatted and require a general title and explanation for each figure. Such as Figure 1 title. A: ; B: ; C: .

Response:

We apologize for any issues regarding the article format and figure presentation. The figures referenced in the original manuscript are all original images and not cited. Furthermore, written consent from the patients was obtained for the use of these images. All images are presented in PPT format, and the legends have been modified as requested.

3. Please obtain permission for the use of picture(s). If an author of a submission is re-using a figure or figures published elsewhere, or that is copyrighted, the author must provide documentation that the previous publisher or copyright holder has given permission for the figure to be re-published, and correctly indicate the reference source and copyrights. For example, "Figure 1 Histopathological examination by hematoxylin-

eosin staining (200 ×). A: Control group; B: Model group; C: Pioglitazone hydrochloride group; D: Chinese herbal medicine group. Citation: Yang JM, Sun Y, Wang M, Zhang XL, Zhang SJ, Gao YS, Chen L, Wu MY, Zhou L, Zhou YM, Wang Y, Zheng FJ, Li YH. Regulatory effect of a Chinese herbal medicine formula on non-alcoholic fatty liver disease. World J Gastroenterol 2019; 25(34): 5105-5119. Copyright ©The Author(s) 2019. Published by Baishideng Publishing Group Inc[6]". And please cite the reference source in the references list. If the author fails to properly cite the published or copyrighted picture(s) or table(s) as described above, he/she will be subject to withdrawal of the article from BPG publications and may even be held liable.

Response:

We sincerely appreciate your kind reminder. The images we used are all original, and we have obtained written consent from the patients for the use of all clinical data. There are no copyright issues with the use of these images. Thank you.

4.Please don't include any *, #, †, §, ‡, ¥, @….in your manuscript; Please use superscript numbers for illustration; and for statistical significance, please use superscript letters. Statistical significance is expressed as $aP < 0.05$, $bP < 0.01$ ($P > 0.05$ usually does not need to be denoted). If there are other series of P values, $cP < 0.05$ and $dP < 0.01$ are used, and a third series of P values is expressed as $eP < 0.05$ and $fP < 0.01$. (5) The title of the case report must end with "A case report" or "A case report and review of quality". If the number of references is < 30, use "A case report"; If the number of references is ≥ 30, use 'A case report and review of quality'.

Response:

We are deeply sorry for any issues related to the article format. We have made the necessary modifications to the symbols and article titles as requested.

Dear Company Editor-in-Chief:

1.I recommend the manuscript to be published in the World Journal of Gastrointestinal Surgery. When revising the manuscript, it is recommended that the author supplement

and improve the highlights of the latest cutting-edge research results, thereby further improving the content of the manuscript. To this end, authors are advised to apply PubMed, or a new tool, the RCA, of which data source is PubMed. RCA is a unique artificial intelligence system for citation index evaluation of medical science and life science literature. In it, upon obtaining search results from the keywords entered by the author, "Impact Index Per Article" under "Ranked by" should be selected to find the latest highlight articles, which can then be used to further improve an article under preparation/peer-review/revision. Please visit our RCA database for more information at: https://www.referencecitationanalysis.com/, or visit PubMed at: https://pubmed.ncbi.nlm.nih.gov/.

Response:

Thank you for the reminder. We have added 11 recent references to enhance the content of the article.

We would like to express our great appreciation to you again for valuable comments on our paper.

Thank you and best regards!

Yours sincerely,

Jing-Hua Kuai