Reply to reviewer's comment regarding the case 2 and case3 (reviewer No 503686)

Comment on Case 2:

1.Actually there was a right level 2 swelling, not submental (wrong entry).

2.U/S was not done prior to the operation .

3. 10 CC pus drained out from the neck region around the fish bone and the abscess cavity extended superiorly to the submandibular region .

4. The pt was kept for 11 days post operation because the wound is sloughy and poor diabetic control and he need to complete the IV Tazocin for one week .

Comment on Case 3:

1. The neck is explored for abscess and to remove the FB , but there is also pus ruptured from the retrpharyngeal wall intraoperatively , that is why we proceed with the D/L scopy and drainage intraoperatively.

2. The neck wound is stil patent during the fistula test and the test was done by instilling the methylene blue into the neck wound and look for any leakage intraorally .

3. The Patient was kept for 11 days post operatively because of the poor control of his DM and the need for dressing of the neck wound .

Reply to the editor:

First of all , we would like to say thank you for the comments and the revisions . Basically we agree with the revisions but we would like to make some changes to the revision .

1. For the title , we agree it to be simple as what the editor suggest .
   Migrating fish bone piercing the common carotid artery , thyroid gland and causing deep neck abscess .

2. Abstract :
   Despite negative laryngoscopy and rigid esophagoscopy, persistent symptoms warrants with further ~~plain neck~~ radiographic imaging studies ~~to be performed~~. ~~Fish bone ingestion can be as simple as impaction in the oral cavity, which can be easily removed or if it migrates, surgical intervention needs to be done.~~ The FB can migrate extraluminally and involve other important adjacent.

3. Case 1:
   Direct laryngoscopy and rigid esophagoscopy under general anaesthesia ~~It~~ revealed an edematous posterior pharyngeal wall but no FB seen . ~~No penetrating wound or puncture site could be seen. There was no evidence of a FB till 25 cm from the upper incisor. Then,~~ contrasted computed tomography (CT) of the neck ~~performed and~~ showed presence of thin.

4. Case 3 :
   One week later, he presented again to the hospital with increasing left neck swelling, ~~and had~~ vomited ~~out~~ pus, but ~~He~~ had no fever ~~at home~~. ~~Upon presentation,~~ there was a diffused swelling at the left side of the neck, firm and tender. Intraorally, there was no FB noted, no medialization of lateral pharyngeal wall and no obvious opening with pus seen. Flexible fiber optic laryngoscopy ~~was conducted again to reevaluate~~ of the upper aerodigestive tract was negative. , ~~but the fish bone was still not detected~~. A contrasted CT of the neck ~~was done~~