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PEER-REVIEW REPORT

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Reviewer's code: 05315303

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Scientific quality	[ ] Grade A: Excellent [ ] Grade B: Very good [Y] Grade C: Good [ ] Grade D: Fair [ ] Grade E: Do not publish
Language quality	[Y] Grade A: Priority publishing [ ] Grade B: Minor language polishing [ ] Grade C: A great deal of language polishing [ ] Grade D: Rejection
Conclusion	[ ] Accept (High priority) [Y] Accept (General priority) [ ] Minor revision [ ] Major revision [ ] Rejection
Re-review	[Y] Yes [ ] No
Peer-reviewer statements	Peer-Review: [Y] Anonymous [ ] Onymous Conflicts-of-Interest: [ ] Yes [Y] No

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SPECIFIC COMMENTS TO AUTHORS

Dear Authors, The submitted case is a rare, interesting case of acute ischemia of the lower extremity due to snakebite venom. There are several points I want to clarify: 1. In general, if there was a complication such as a local tissue reaction (3 cm×2 cm ulcerated area with a hemorrhagic crust on the left dorsum (Figure 1A) in this case) after a venomous snake bite (Bite injury 10 days prior in this case), we considered antivenom administration initially or in the course of treatment. If it is assumed that the patient's artery occlusion is accelerated or intensified by the pro-coagulatory or hyper-coagulatory effect caused by snake venom, we cannot clearly estimate the treatment effectiveness (whether the antivenom prevented or relieved thrombotic effect in patient), but wasn't the antivenom administration an important factor to consider for the patient condition? I think this is better to be addressed in the discussion. 2. Unlike VICC(Venom-induced consumption coagulopathy) induced hemorrhagic patients, in this case, fibrinogen was higher than normal, and D-dimer was almost normal. It is known that snake venom may increase blood clot formation by consumptive and procoagulant coagulopathy similar to DIC, which may eventually lead to hemorrhagic complications. In relation to hyper-coagulopathy promoted by snake venom in this patient, hematological and coagulopathy profiles such as BT, PTT, aPTT, and PLT count, which are general blood coagulation test items other than fibrinogen and D-dimer, were not described. Are these tests excluded because it is normal range? Explaining this clearly is expected to help readers better understand the difference between this case patient and a patient with VICC hemorrhagic complications. 3. It is understood that previous hospital has diagnosed artery occlusion through CT angiography. The time frame, such as transfer of patient before CDT treatment, is not clear, but has there been no administration of antithrombotic agents (anticoagulants, antiplatelet agents) since the diagnosis of artery occlusion? It would be nice to have a

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description of this. 4. A 6-day course CDT treatment for peripheral artery occlusion in this patient is described. As far as I know, standard techniques don't exist. However, if you describe in detail the thrombolytic agent used, the dose, and the delivery method (eg continuous infusion, bolusing, pulse spray, graded infusion, and stepwise infusion? etc.), it will be a great help and reference treatment guide for readers in the treatment of similar case patients in the future. Thank you!