Dear editors:

Thank you very much for your valuable comments. According to these comments, I have revised my article in detail.

To Reviewer #1:

The patient experienced difficulty swallowing for six months, and the symptoms had worsened in the two weeks prior to admittance' Could be rewritten as 'Our patient had progressively worsening dysphagia over a period of 6 months with an acute deterioration over the preceding 2 weeks leading to the admission

This sentence has been revised according to opinions.

Clarification is needed with regards to the need for 'repeated ultrasound guided thoracic puncture and drainage'. If this modality was noted to be ineffective, what was the rationale to pursuing with this?

Clarification has been added. Because of its convenient operation, less trauma and good patient tolerance, percutaneous ultrasound puncture has a good drainage effect on postoperative pleural effusion and ascites and early infectious exudate.

In the case presentation section, only the examination findings at the initial diagnosis of the gastric carcinoma has been written. There is no mention of the examination findings at the time of the diagnosis of the ensuing complication. Is there a role for oral gastrograffin contrast ingestion of a low toxicity in the diagnosis of anastomotic leak? It has noted that this was used in the post procedure phase to ensure resolution of the complication.

The part of final diagnosis has been modified. Oral blue-dimethylene test and CT examination were performed when anastomotic leakage was highly suspected after operation.

To Reviewer #2:

How long is the percutaneous drain maintained?

The percutaneous drain was maintained for 18 days.

Has the author examined bacterial resistance cultures in these patients?

Bacterial resistance cultures of ascites, bile and pleural drainage pus were performed. The results showed that human Staphylococcus was infected.

What antibiotics were given to this patient?

According to the drug sensitivity results, Piperacillin sodium, tazobactam and imipenem were given gradually

Please discuss the cause of leakage anastomosis in this patient! These conditions include very early anastomotic leakage, which is not common in less than 5 days after the operation.

The causes of anastomotic leakage may be related to the following factors: tumor infiltration leads to esophageal wall edema and poor healing after anastomosis; Anastomotic tension; Hypoalbuminemia, etc.

Please explain the limitations of this case report!

More samples are needed to evaluate the effectiveness of this method, and intraoperative gastroscopy is recommended to check the anastomotic condition.

To EDITORIAL OFFICE'S COMMENTS

Can the author supplement the maintenance time of skin drainage? In addition, bacterial drug resistance culture was supplemented?

These comments have been revised already.