

Reviewer #1:

Recommendation	Reply
Recommendation 1: Title : Suggest to expand the abbreviation DSA and state in the list of abbreviations (not completed). Also suggest to use the universally accepted terms for SEMS - expandable/expending.	Reply 1: Thank you for your guidance, The title has been revised in accordance with comments, and also followed to use the universally accepted terms for SEMS - expandable/expending.
Recommendation 2: Introduction : despite mentioning several times in abstract that this is the first reported case of stenting in proximal bowel, this has indeed been written in several articles. One article even mentioned stenting done at TI. Suggest to omit or write as "few studies" (reference : DOI: 10.29271/jcsp.2019.12.S89 and 10.1155/2012/296347)	Reply 2: Thank you for your guidance, Your suggestions have been followed to write as "few studies".
Recommendation 3: Case presentation : Many important pertinent history and clinical examination findings were not included. (e.g. family history, constitutional symptoms, any colonoscopy/biopsy etc.). Why was this patient planned for palliative care? Did CT staging revealed any mets? Any oncology referral? Was it the patient's wish? Despite the age of 88 years old, ECOG status should be stated to support the decision for palliative care.	Reply 3: Thank you for your thoughtful consideration, we have followed your suggestion and improved all the information to History of past illness, we look forward to your further reading! The patient complained of generalized abdominal pain and distension with associated nausea,vomiting,and constipation for 10 d. On admission, computed tomography (CT) of the abdomen suggested acute intestinal obstruction, otherwise no significant metastases were detected. To make a definite diagnosis,endoscopic examination was considered; however, the family members refused. In combination with the abdominal CT, the patient was considered to have a high probability of malignant obstruction and was recommended to undergo ileostomy. However, after a multidisciplinary discussion, the

	<p>anesthesiologist advised against the surgical operation, in view of the patient's advanced age and underlying diseases, such as coronary heart disease and frequent premature atrial beats as suggested by an electrocardiogram. Furthermore, systemic chemotherapy was not recommended because the patient was weak, was bed-ridden, and Eastern Cooperative Oncology Group (ECOG) score was 3. Moreover, palliative treatment was the only choice to improve the patient's quality of survival. Therefore, SEMS placement was considered for this patient, although the distance from the anus to the obstruction site was long, and the procedure was considered extremely difficult.</p>
<p>Recommendation 4:</p> <p>Discussion : suggest to summarize as it is unnecessary to describe again what was done. Instead, previous studies documenting outcomes with statistical data to support the good outcomes of such procedure would be much more valuable. (eg. Post op death avoided, period of immobilization or length of hospital stay comparing stenting and surgery. etc.)</p>	<p>Reply 4:</p> <p>Thank you for your thoughtful consideration, the discussion section has been trimmed as you suggested.</p> <p>Many studies have been published within the last 20 years regarding the efficacy and safety of SEMS in colon cancer. Khot et al^[8] reported a systematic review of case series between January 1990 and December 2000, in which 598 patients were analyzed. Technical success, expressed as stent placement and deployment, was achieved in 92% (551 stent placement attempts). Clinical success, defined as a colonic decompression within 96 hours without surgical or endoscopic intervention, was attained in 88% ($n=525$)^[9]. Sukit et al^[10] reported a systematic review of case series between 2009 and 2019. Although the patency of SEMS reported was shorter than for stoma creation; however, SEMS patency was not much different from that of stoma within the first year (88.9 vs. 93.2% in 6 months; 84.1 vs. 90.5% in 12 months).</p>

	<p>Furthermore, the 1-year re-intervention rates did not differ between SEMS insertion and stoma creation. Despite the lower SEMS patency rate after 1 year, 84% of the patients who underwent SEMS placement did not require any re-intervention until death. This finding suggests a short overall survival of patients with incurable metastatic disease. On the other hand, palliation for malignant gastro-intestinal and biliary obstruction with SEMS deployment show a long-term outcome of 70% stent patency until death^[11-12], which is considered acceptable.</p>
<p>Recommendation 5: Conclusion? Maybe the last paragraph of the discussion can be used as the conclusion.</p>	<p>Reply 5: Thank you for your guidance, Conclusion section has been added to the article.</p>

Reviewer #2:

Recommendation	Reply
Recommendation 1: In the article title, using the expression "self-expanding" or "self-expandable" metallic stent would be more accurate than "self-expanded".	Reply 1: Thank you for your guidance, The title has been revised in accordance with comments, and also followed to use the universally accepted terms for SEMS – expandable/expending.
Recommendation 2: A major issue is that the authors state in different sections of the manuscript that there are no previous reports of this procedure. However, there are at least two articles available in Pubmed that describe similar procedures, and should be acknowledged (DOI:10.1055/s-0043-113560 and DOI:10.1155/2014/372918).	Reply 2: Thank you for your guidance , Your suggestions have been followed to write as “few studies”.
Recommendation 3: The history of past illness, personal and family history, physical examination, laboratory examination and conclusion sections are blank. These sections must be filled out with relevant data to the case (Was there a previous history of weight loss, abdominal pain or change in bowel habits? Was there a family history of cancer? Was the abdominal mass palpable?	Reply 3: Thank you for your guidance.All relevant medical histories have been added to the article where required and we look forward to your next reading. <i>History of past illness</i> He had been diagnosed with hypertension for 28 years, coronary heart disease for 20 years, and diabetes for 3 years. He had experienced previous occasional

<p>Did the patient had leukocytosis or anemia at presentation?)</p>	<p>abdominal pain, change in stool pattern for 10 months, and weight loss of 5 kg in the last 3 mo.</p> <p><i>Personal and family history</i></p> <p>The patient denied any family history of malignant tumors.</p> <p><i>Physical examination</i></p> <p>His vital signs were stable. The abdomen was distended, gastrointestinal type visible, and diffusely tender. There was no rebound tenderness, but abdominal auscultation revealed hyperactive bowel sounds.</p> <p><i>Laboratory examinations</i></p> <p>The blood work at admission showed moderate normocytic anemia. The levels of the following serum tumor markers were elevated: carcinoembryonic antigen, 50.9 ng/mL and carbohydrate antigen 19-9, < 2 U/mL.</p>
<p>Recommendation 4:</p> <p>Describing what was the nature of the patient's contraindication to general anesthesia would be of primary importance in this case report.</p>	<p>Reply 4:</p> <p>Thank you for your thoughtful consideration. Contraindications to general anesthesia include mainly the patient's advanced age, admission ECG suggests: premature atrial beats .He had poor cardiopulmonary function and was in a state of unconsciousness shortly after hospitalization, including at the time of surgery.</p>
<p>Recommendation 5:</p>	<p>Reply 5:</p>

<p>The patient is said to have been stabilized prior to the procedure - was he hemodinamically unstable at presentation?</p>	<p>Thank you for your thoughtful consideration. The patient had a history of severe pulmonary infection at presentation, and blood tests on admission also suggested moderate anaemia and a poor general condition, and was only operated on after a multidisciplinary consultation and relative stability. This is reflected in the additional article content.</p>
<p>Recommendation 6: Were there any signs of metastatic disease in the imaging exams?</p>	<p>Reply 6: Thank you for your thoughtful consideration. No obvious signs of metastasis on imaging, which is reflected in the CT.</p>
<p>Recommendation 7: While the authors state that the usual surgical treatment for this case would be a jejunostomy, it would actually be an ileostomy.</p>	<p>Reply 7: Thank you for your guidance. Changed jejunostomy to ileostomy as per your suggestion.</p>
<p>Recommendation 8: All abbreviations must be written in full the first time they appear in the text (DSA: digital subtraction angiography - this is also missing in the abbreviation list at the end of the manuscript).</p>	<p>Reply 8: Thank you for your guidance. Now changing DSA to fluoroscopic guidance.</p>
<p>Recommendation 9: There are some minor corrections in the treatment section (the catheter should be said to be "too short for reaching" the obstruction; vertebral catheter instead of vertebral cater).</p>	<p>Reply 9: Thank you for your guidance. Modified as per your suggestion. Under fluoroscopic guidance, the vertebral catheter was rotated, advanced, walked up, and intermittently traveled over the guidewire through the rectum into the sigmoid colon and, finally, to the hepatic flexure of the colon. The catheter was too short of reaching the ileocecal region. After the injection of contrast, the persistent</p>

	occlusion of the ileocecal region was seen, with no apparent bowel movement on repeated observation. We managed to push the wire through the lesion but failed because the vertebral cater was not close to the lesion, and the wire did not have enough backup.
<p>Recommendation 10:</p> <p>Finally, in previous descriptions SEMS are used in colon cancer as a temporary treatment before definitive surgery. In the case reported, it was used as a definitive palliative treatment, and while not mandatory, it would be of great scientific interest if the authors could provide medium- and long-term information on the patient follow-up.</p>	<p>Reply 10:</p> <p>Thank you for your guidance. I am very sorry to say that the patient was discharged from the hospital in this case in a general state due to the fact that the patient's family strongly requested to be discharged after the surgery, the bloated environment and later, the family could not be contacted again after the discharge. Survival time long etc. is not known.</p>