Round 1

The author conducted research and clinical literature review on traumatic appendicitis. This is a very interesting clinical research topic. Traumatic appendicitis is relatively rare in clinical practice. The main reason is how to define trauma as the cause of appendicitis, how to cause it, and how long does it take to cause it? All of these troubles clinical doctors in making a diagnosis of traumatic appendicitis. Therefore, this manuscript has certain guiding significance for clinical practice and has good readability. Has a certain degree of innovation. Pay attention to reducing the length appropriately and avoid writing the discussion section as a literature review. Focus on elaborating on research findings. Suggest publishing after modification.

Response：

Year	Author	Number of cases	Age (y)	Mechanism of injury	Time of presentation	WBC	Investigations	surgery	Findings
1991 [2]	Hennington	2	46 12	RTA Fall	48h 12h	16900 13000	CT(free fluid) -	Laparotomy Laparotomy	Isolated Isolated
1991 [3]	Bangs	1	20	RTA	Few hours	3250	CT	Laparotomy	Isolated
1995 [4]	Musemeche CA	1	4	RTA	Few hours	22900	CT	Laparotomy	Isolated
1995 [5]	Stephenson BM	1	32	Seat belt	120h	-	-	Laparotomy	Wedge fracture of T10
1996 [6]	Serour F	3	11 8 7	Assault Fall Assault	1h 3h 7days	4500 20100 -	CT 0 CT	Laparotomy Laparotomy Laparotomy	Isolated Isolated Isolated
1996 [7]	A.O. Ciftçi	5	8 5 13 14 7	RTA Fall Ball RTA Assault	2h 6h 12h 4h 12h	9800→ 18000	- - - US US	Laparotomy Laparotomy Laparotomy Laparotomy Laparotomy	Head injury Rib fracture Isolated Head injury Head injury

1999 [8]	R. Edwards	1	41	RTA	Hours	-	CT	Laparotomy	Ileocecal lesion→ ileocecal resection
2000 [9]	Osterhoudt KC	1	9	RTA	Hours	-	CT(NL)	Laparotomy	Isolated
2000 [10]	Takagi Y	1	45	Seat belt	24h	-	-	Laparotomy	Isolated
2001 [11]	Ramsook C	1	12	Assault	7h	15400	CT	Laparotomy	Isolated
2001 [12]	Houry D	1	5	Fall	1h	-	CT	Laparotomy	Isolated
2002 [13]	Hager	1	60	Fall	72h	-	CT	Laparotomy	Incarcerated direct hernia
2002 [14]	Ramesh G	1	11	bicycle	48h	NL	US	Laparotomy	Isolated
2004 [15]	Karavokyros I	1	21	Assault	Hours	-	US	Laparotomy	Isolated
2005 [16]	Etensel B	5	5 8 14 9 13	RTA RTA RTA Fall RTA	4h 1h 1h 1h 0.25h	18700 19500 12200 17700 19400	US US US US-CT CT	Laparotomy Laparotomy Laparotomy Laparotomy Laparotomy	Multiple hepatic lacerations Right diaphragmatic rupture + liver laceration + retroperitoneal hematoma Retroperitoneal hematoma Isolated Left diaphragmatic rupture + splenic laceration + left ureteropelvic junction rupture
2006 [17]	Volchok J	1	60	Colonoscopy	60h	13700	CT	Laparoscopy	Isolated
2009 [18]	Derr C	1	41	Fall	24h	-	US-CT	Laparoscopy	Isolated
2009 [19]	Amir A	1	10	Fall	2h	NL	US-CT	Laparotomy	Isolated
2010 [20]	Zaher Toumi	1	11	Assault	3 days	-	CT	Laparotomy	Isolated
2012 [21]	O'Kelly	1	29	Ball	24h	17470	CT	Laparotomy	Isolated
2012 [22]	Konstantinos A Paschos	1	17	Bicycle	12h	12700	US	Laparotomy	Isolated

2013 [23]	Wani I	8	9-63	3 fall-4assault 1 bicycle	24h-4 days	-	US-CT	Laparotomy	Isolated
2013 [24]	Bouassria et al	1	24	Stab	24h	14000	US(2nd)	Laparotomy	Retroperitoneal hematoma
2013 [25]	Moslemi S	1	13	Bicycle	6h	14700	US-CT	Laparotomy	Rupture of the small bowel mesentery
2016 [26]	S.J. Go	1	23	Seat belt	0.5	-	US-CT	Laparotomy	tearing of the distal ileum mesentery
2017 [27]	Muhammad Faisal Khilji	1	43	RTA	2h	11000	US-CT	Laparoscopy	Isolated
2017 [28]	Travis Cobb	1	17	RTA	24h	10800	CT	Laparoscopy→laparotomy	Isolated
2018 [29]	Aljaberi	1	24	Seat belt	24h	-	CT	Laparotomy	Transection of the omentum
2018 [30]	Aykut Çağlar	1	12	Fall	24h	21020	CT	Laparotomy	Isolated
2018 [31]	Javariah Siddiqui	1	22	Fall	3h	7500	CT	Laparoscopy	Isolated
2019 [32]	Z. Zvizdic	1	7	Horse kick	10h	11500	US-CT	Laparotomy	Isolated
2022 [36]	Karen Juliana Salinas-Castro MD	1	14	Soccer ball	6h	-	US-CT	Laparoscopy	Isolated
2022 [37]	Samuel Goldman	1	11	Assault	24h	22000	MRI	Laparoscopy	Isolated
2023	Our study	1	12	Fall	3 days	14500	US	Laparotomy	Isolated

Round 2

Dear reviewers, thank you very much for your interest in our manuscript and for your valuable comments. Here is a point-by-point response to each reviewer comment:

1. The child fell. Fell on right side. Injured hand. Did he injure abdomen? Was there direct trauma to abdominal wall? Was there pain over abdomen immediate after fall? Did he complain abdominal pain over the next couple of hours after the fall? - this is important as simply otherwise it can be postulated that the child had developed de novo acute appendicitis, this was untreated, it progressed, it perforated, child was unwell and he fell down. Thus the falling incident has to be correlated with caution as an aetiology rather than merely coexisting condition. Authors must make enough details available in case report to eliminate all doubts about this or else this case report cannot be published.

➔ Prior to the fall, the child had been doing well. That was the primary reason for suspecting post-traumatic appendicitis.

In terms of the fall, he fell on his right side, including the right side of his abdomen, but no abdominal tenderness was found during the initial physical examination. The abdominal pain began later that day.

All these details were mentioned in the case presentation: history of past illness and physical examination.

2. Out of Fowler 4 criteria - what about your case - which criteria fulfilled? Please discuss this in discussion segment.

➔ In the discussion section, we stated that all patients, including our patient, met the Fowler inclusion criteria. The phrase "In this review, all patients met the inclusion criteria, and the diagnosis was confirmed by a histopathological study" was added.

3. You did not suspect appendicitis based on history and tests done. X ray showed possible intestinal obstruction. Ultrasound should pelvic abscess. So your provisional diagnosis MUST be mentioned in case report and not just final diagnosis. In this am i right to read that the final diagnosis was done only after surgery was done? Before surgery you had obstruction as diagnosis? Please make sure that this is clear to readers.

➔ We have added in the manuscript that the initial diagnosis was posttraumatic bowel perforation. We also mentioned that the diagnosis of acute traumatic appendicitis was made intraoperatively.

4. Why did you not do laparoscopy? What was the incision - midline? paramedian? horizontal? I say so as it is a morbid approach due to long term risks of adhesions and small bowel obstruction + incisional hernia. So to laparotomize young child is a big issue. Please explain local resources and policies in method section.

➔ The incision was added to the case presentation as "an urgent exploratory laparotomy was performed via a midline incision."

We were hesitant to use a laparoscopic approach because the patient was unstable and had no preoperative diagnosis. This was mentioned in the discussion section. "Laparotomy is commonly performed due to the trauma and the risk of associated hemorrhagic lesions that may necessitate additional treatment"[16]. In stable cases with a positive preoperative diagnosis, laparoscopy may be indicated."

5. Discussion segment is a bit weak with no focus on source control importance to reduce morbidity and mortality (PMID: 37480129), missing discussion on non-operative management of appendicitis (PMID: 34950421), occasional need for doing right hemicolectomy in complicated appendicitis patients (PMID: 29796684) (as described in your citation 8 of R Edwards et al) and this should be best avoided in young patients to preserve ileocecal valve and its physiologic benefits, role of resources and training in minimal access surgery (PMID: 36707879).

➔ In all cases of acute traumatic appendicitis, surgery is required, thus non-operative management was not discussed.

The primary cause of morbidity and mortality in this case is a lack of a clear diagnosis and appropriate management. That is why we have emphasized the significance of taking the diagnosis into account.

In children, hemicolectomy should be avoided, and bowel resection should be considered only in cases of injured segments. We insisted on it in the discussion.