1. Q: There is a problem with the logical representation of the article title. I think it should be discharge from the intestine and not from the stool.

A: we take this idea, making a title: neurofibroma discharged from anus with stool: A case report and literature review.

2. Q: The 'isolated' in keyword section should be replaced with a noun.

A: it is an adjective, but it is the most specific character of this case, and it is the point that we want to share with the reader, so we still want to keep it.

3. Q: The language needs improvement. There are several misuse in the article, such as 'without any blood' in abstract section, 'blood may' be change into 'bleeding'.

A: since we are non-native speakers of English, there are must some misuse in this paper, and we will do our best to correct it, but in this "blood" issue, we mean that there was not blood on the discharged neurofibroma, not the patient have a bleeding symptom, so how about "a neurofibroma in her stool without any blood."

4. Q： There is no indication in the text whether the patient had been examined in other hospital after the tumor had been discharged.

A：in the case report section, the 4th, 5th, and 6th sentences of the first paragraph are all talk about the lab or endoscopic examinations that been taken in other hospital, and maybe we should make more clear, and the for the

physical examination weather or not in other hospital, it has been already 4 month since that time, and the patient was not for sure, so we were not mention that in this paper.

5. Q: The surgical procedure should be described in detail.

A : Endoscope expert thought that the case is not indicated for endoscopic resection, and the patient refuse laparosopic surgy.

Preoperative diagnosis: ileocecal neoplasia.

Procedure: ileocecustomy with primary anastomosis.

Postoperative diagnosis: ileocecal neurofibroma

Indications: This 24-year-old female with abdominal pain symptoms, a neoplasia was found to have involving the ileocecus. Elective resection was indicated.

Description of procedure: The patient was placed in the supine position and general endotracheal anesthesia was induced. Preoperative antibiotics were given. A Foley catheter and nasogastric tube were placed. The abdomen was prepped and draped in the usual sterile fashion. A time-out was completed verifying correct patient, procedure, site, positioning.

A skin incision about 10cm was made in a natural skin line centered over McBurney's point, the abdomen was explored. Adhesions were lysed sharply under direct vision with Metzenbaum scissors. A mass was palpated in the ileocecus, about 5*6 cm. The liver, omentum, peritoneum, and ovaries were inspected for the evidence of metastatic disease.

The small bowel was inspected and retracted to the left using a moist gauze and retractor. Using electrocautery, the colon was freed from its peritoneal attachments along the avascular line of Toldt from the cecum

to the hepatic flexure. Additional lateral peritoneal coverings were incised to further mobilize the colon. The dissection was extended across the ileocolic junction and terminal ileum was mobilized. Both ureters were identified and protected, as were the duodenum, right kidney, and gonadal vessels. The hepatic flexure was carefully mobilized by dividing the peritoneum in the hepatorenal fossa.

The distal ascending colon about 6cm away from the neoplasia was set the point to be cut. The bowel was divided with the linear cutting stapler and the pre-set point. The peritoneum overlying the mesentery was then scored with electrocautery and the ileocolic artery was identified, double ligated with 2-0 silk sutures. The specimen was removed, proximal and distal ends tagged, and sent to pathology. And the result come to be a spindle-cell tumor or neuroendocrine tumor.Hemostasis was checked in the operative field. The two ends of bowel were checked and found to be viable, with excellent blood supply.

The fat was gently cleared from the terminal 2–3 mm of the bowel ends. The ileum and the colon ends of bowel were brought into apposition and found to lie comfortably without excessive tension. A Cheatle slit was made in the antimesenteric border of the ileum to equalize the caliber of the two pieces of bowel. A two-layer hand-sewn end-to-end anastomosis was then constructed using an outer layer of interrupted 3-0 silk Lembert sutures and an inner running layer of 3-0 Vicryl.

The anastomosis was checked and found to be intact and widely patent. Mesenteric defect was closed with interrupted 3-0 Vicryl. The abdominal cavity was then copiously irrigated and hemostasis was checked.

The patient tolerated the procedure well and was taken to the postanesthesia care unit in stable condition.

6. Q: The authors mentioned in the discussion that diffuse neurofibromatosis

is easily confused with Crohn's disease. But the author did not mention that isolated neurofibromatosis needs to be differentiated from which diseases.

A: The isolated neurofibromatosis present may different symptoms, it can have one or more, even all of the clinical presentations, so the differentiated diseases are not also the same. For example, in the case we report, the patient just have abdomen pain, so differentiated from these diseases that can cause pain, such as appendicitis, cholecystitis, Gastroenteritis; when comes to altered bowel habits including constipation or diarrhea and/or palpable abdominal masses, the cancer of colon should be considered; and when comes to intestinal obstruction, the bowel obstruction also should be considered. There is no a fixed Spectrum of Disease that isolated neurofibromatosis was differentiated from, it is adopted with the clinical presentations

7. The discussion section should further illustrate the clinical significance of this particular case.

A: the most and only clinical symptom of this particular case is the patient presents a month-long history of abdominal pain after meals besides Forty days ago, she found an lump in her stool without any blood on it. The unique character of this case is lack of the classic neurofibromatosis presentation, without the lump history, and the biopsy result, you may never come to this disease. And the neurofibromatosis discharged for intestine with stool is also first time to reported, which can abundant the clinical presentation of this disease.