March 27, 2019

To: Ze-Mao Gong and Jin-Lei Wang

We wanted to thank you and all the peer reviewers for taking the time to review our manuscript. We have carefully read the comments of all reviewers and have modified our manuscript in order to improve it based on the comments. Please see below our point-to-point responses to each of the reviewers' comments. Also, please see the revised manuscript as it has the changes mentioned below. Once again, thank you for your time.

Sincerely,

Adalberto Gonzalez MD
Department of Internal Medicine
Cleveland Clinic Florida

To Reviewer 00503257:

Point 1: "This case report is potentially interesting. However, the whole volume of description is too large which should be much reduced concisely.
Particularly in discussion section, there was too much well-known and unnecessary general information. This section should be rewritten focusing on their novel findings. General information should be limited. "

Answer 1: Thank you for taking the time to peer review our manuscript. We have revised the manuscript and have made an effort to eliminate any unnecessary or repetitive information.

Point 2: The authors should review previous reports of lupus enteritis and discuss their patient compared to that of previously reported patients.

Answer 2: Thank you for reviewing our manuscript. We have clarified why our case is rare. It is uncommon for lupus enteritis to be the only and initial manifestation of active SLE. In paragraph 1 of the discussion (page 8), we have noted that lupus enteritis as the only active manifestation of SLE is rare finding, seen only in a few case reports. In addition, few cases of lupus enteritis occur as the initial presenting manifestation of SLE. Much of the information from the discussion comes from case report sources as cited by references 4-12. We have revised the manuscript to include more comparisons and case report sources.
In addition, there is a scarce evidence describing the management of moderately severe lupus enteritis in a patient unable to tolerate by mouth intake. The dilemma is whether the patient should be treated with pulse dose steroids/immunosuppressants or whether 1 mg/kg of IV methylprednisolone is enough. Our case adds evidence that you may start with 1 mg/kg of IV methylprednisolone. Finally, there isn't much evidence regarding maintaining

remission in patients with lupus enteritis. After 12 months of being on Hydroxychloroquine, our patient retained remission. We feel that these are points that can aid physicians managing lupus enteritis in the future.

Point 3: "I know that lupus enteritis presented with the other organ damage such as lupus cystitis. Thus, further follow-up should be needed in this patient. This issue should be clearly stated in the main text and abstract."

Answer 3: In this patient, there were no other clear manifestations of other organ involvement. During her work-up, she did have work up to screen for lupus nephritis with daily basic metabolic panels (while hospitalized) and a urine protein:creatinine ratio. This was negative for any proteinuria; thus, there was no further work up needed. We have included this in the manuscript as part of the revision.

In addition, the patient had no indication of dysuria, hematuria, urinary frequency, or other urinary symptoms to suggest lupus cystitis. The patient has continued to follow up with her Rheumatologist who is treating her with Hydroxychloroquine; the patient has not had any recurrence of symptoms related to lupus enteritis or other manifestations of SLE since being on the Hydroxychloroquine for more than 12 months. This has also been added to the manuscript.

To Reviewer 00505859:

Point 1: "One apparent omission in consideration and workup is antiphospholipid syndrome."

Answer 1: Thank you for taking the time to peer review our manuscript. The patient did not have any evidence of venous or arterial thromboembolism on

history, physical exam, or imaging. Thus, we did not do a diagnostic workup for antiphospholipid syndrome.