Answers to Reviewers: Thank you for taking time out of your busy schedule to review our manuscript and provide your invaluable comments. We have carefully studied the "Peer-Review Report", and have reconsidered the weaknesses of our manuscript. The manuscript has been improved according to the suggestions. Point-by-point response to comments are as follows:

1." Doppler ultrasound (US) and computed tomography (CT) showed a bulge in the bowel, leading to a diagnosis of a sacrococcygeal hernia" Why did the authors use Doppler USS as part of their work up? Was contrast enema given prior to acquisition of the CT? Furthermore was endoscopic assessment of the colon performed to exclude sinister pathology prior to embarking onto the repair?

Response: The patient's Doppler ultrasound (US) was conducted in other hospital before visiting our clinic. The physical examination of the patient detected obvious abnormality, therefore, we agree that US makes little difference to the diagnosis. Contrast enema was not given prior to acquisition of the CT. As the patient had a history of constipation, endoscopic assessment of the colon had been previously performed to exclude sinister pathology.

2. The period of follow up is not consistent in the text (appears to vary between 3 and 6 months)- can the authors clarify? How did they define recurrence on follow-up? Was it on radiological or clinical grounds?

Response: We apologize for the inconsistence of the follow-up period in the text. It was a clerical error. The surgery took place on April 1st, 2019, and the patient was followed up for more than 6 months by now. Recurrence was defined as relapse of the sacrococcygeal bulge. Since the local subcutaneous fat layer was very thin, and palpation could detect accurately, thus recurrence could usually be judged based on clinical examinations on follow-up.

3. Multiple references are missing in Discussion as the authors make various

statements which are not followed by any citations. Can the authors please correct?

Response: Citing of reference literatures in Discussion have been corrected.

4. What influences the choice of mesh in such rare hernias in the authors' opinion? It is not clear in the text

Response: In our opinion, the pathogenesis, anatomic site and fixing requirement are three main influencing factors on the choice of mesh in such rare hernias. This case was to repair bulging, and the surgical mesh was to be placed into the extraperitoneal space of pelvic floor with minimal risk of intestinal erosion, and meanwhile in order to avoid injury of presacral venous plexus, a polyester mesh with polylactic acid grips was eventually chosen to reduce fixation with suture.

5. Why was not the mesh fixed to the sacrum laparoscopically since the rectum, mesorectum were mobilised and access was available?

Response: We did not fix the mesh laparoscopically because we thought that the suturing via sacrococcygeal approach was more convenient and safe, with less worry about injury of presacral venous plexus. But through the surgical experience of this case, we think that totally laparoscopic surgery can be a priority once the surgeons are familiar with the anatomy of the sacrum anterior and skilled at suturing under laparoscopy.