ROUND 1

1. There are also many text formatting errors, such as missed or double spaces, unnecessary symbols, capital letters in the middle of the sentence, unjustified paragraphs.

We have revised.

2. Core tip and ORCID IDs are missing in the manuscript file.

We have added in the manuscript.

3. Author contributions are not detailed according to the journal requirements. All authors and their role in writing this manuscript must be provided.

We have added in the manuscript.

4. The Case presentation part is structured not according to the journal requirements. Please organize your manuscript using correct paragraphs (chief complaints, history of present illness, history of past illness, personal and family history, physical examination, laboratory examinations, imaging examinations, final diagnosis, treatment, outcome and follow-up).

We have revised.

5. The laboratory examination part could be more detailed, e.g., CRP, HgB, other important tests.

We have added in the manuscript.

6. Do you have the primary ultrasound images of the inguinal B-ultrasound? Do you have histological images?

We have added in the manuscript.

7. Please correct figure 4 – one of the terms is in Latin: "arteria iliaca externa."

We have revised.

8. Please add DOI and PMID in the references part.

We have added in the manuscript.

9. Please correct the text formatting errors.

We have revised.

10. It would be interesting to include what kind of antibiotic treatment was used and for what period of time.

We have added in the manuscript.

11. In figure 4, one of the subtitles is in portuguese (external iliac artery).

We have revised.

12. Please provide the English language editing certificate issued by the language editing company

We have provided.

13. Please provide manuscript in MS Word format, and the manuscript in any other format will be rejected.

We have provided.

14. The "Author Contributions" section is missing.

We have added in the manuscript.

15. The authors did not provide the approved grant application form(s).

We have provided.

16. The authors did not provide original pictures.

We have provided.

17. PMID and DOI numbers are missing in the reference list.

We have added in the manuscript.

18. The "Case Presentation" section was not written according to the Guidelines for Manuscript Preparation.

We have revised.

ROUND 2

Reviewer #1: Dear Author, First of all, thank you for revising your manuscript. It looks better after revision. However, the manuscript's English language and text editing still need revision (some grammar and spelling mistakes, missed spaces). The raised issues are answered partly. The answering reviewers letter is very unclear. You should provide exact answers to raised questions in the answering reviewers letter (the response “We have added in the manuscript” is very abstract. There is also one question not answered in the letter (“In the discussion part, I suggest summarizing the recommended surgical treatment options (whether or not to perform appendectomy) in a graphical way: a scheme or a table. This way, it would be clearer and more memorable).

However, you have to indicate findings with arrows (figure 1). Please provide magnification for the histological image. Also, arrows and text in the figures (ppt) must be editable. Figure legends are not formatted according to the guidelines. The legends need titles before descriptions. All in all, the manuscript still needs revision.

The manuscript's English language and text editing has been revised.

Table 1 Surgical methods as determined by severity of appendiceal inflammation.

Figure 1 Inguinal B-ultrasound. The right inguinal canal was involved, and there was no obvious reduction after pressurization with probes.

Figure 2 Appendix and femoral ring. The arrow shows the appendix. The appendix and its mesangium herniated into the femoral ring without reduction, and the color of the proximal segment was normal.

Figure 3 Tractus iliopubicus. The arrow shows the tractus iliopubicus. Part of the tractus iliopubicus was cut using an electric hook to return the appendix.

Figure 4 The distal segment of the appendix. The distal segment of the app endix and its mesangium were dark in color with avascular necrosis and surfac e exudation.

Figure 5 The femoral ring. After reduction, the femoral ring could be observ ed. The partially severed tractus iliopubicus is shown.

Figure 6 Pathological analysis of the appendix. The postoperative pathology report showed that a large number of neutrophils infiltrated the wall of the ap pendix and mesangial fat, and hemorrhagic necrosis was also observed in the mesangium(magnification: ×50).

Arrows and text in the figures (ppt) can be editable.

Reviewer #2: The reviewed version of the manuscript shows significant improvement in formatting and includes a more detailed account of the treatment in general and of the surgical procedure in particular. Writing in the english needs further revision, however.

Writing in the english has been revised.

Reviewer #3: Dear Author, First of all, thank you for submitting your manuscript to the World Journal of Gastrointestinal Surgery. This is an interesting article about an unexpected finding of De Garengeot hernia in a patient with right grown pain. However, the manuscript's scientific English language needs major revision. There are also many text formatting errors, such as missed or double spaces, unnecessary symbols, capital letters in the middle of the sentence, unjustified paragraphs. The case report aims to raise the clinician's awareness of De Garengeot's hernia. It also provides detailed laparoscopic images. In my opinion, it might become worth publishing after major revision and supplementation.

1. Core tip and ORCID IDs are missing in the manuscript file.

ORCID number: Min-Quan Yao 0000-0001-8567-9021; Bing-Hong Yi 0000-0003-0498-7204; Yong Yang 0000-0002-7785-8182; Xiao-Qi Weng 0000-0001-5194-3883; Jin-Xing Fan 0000-0003-2003-7858; Yu-Peng Jiang 0000-0001-9250-3606.

Core Tip: Clinicians should be aware of the fact that a De Garengeot hernia has a low incidence and is difficult to diagnose in the early stages. When a De Garengeot hernia is clinically suspected, B-ultrasound or computed tomography and emergency surgical treatment should be performed as soon as possible. Laparoscopy is useful for the diagnosis and treatment of De Garengeot hernias and is thus worthy of clinical application.

2. Author contributions are not detailed according to the journal requirements. All authors and

their role in writing this manuscript must be provided.

Yao MQ and Yi BH wrote the manuscript. Yang Y and Weng XQ collected the information and images. Jiang YP and Fan JX reviewed the manuscript. All authors have been involved in drafting the manuscript and revising it critically for important intellectual content; All authors read and approved the final manuscript and take public responsibility for appropriate portions of the content and agreed to be accountable for all aspects of work.

3. The Case presentation part is structured not according to the journal requirements. Please organize your manuscript using correct paragraphs (chief complaints, history of present illness, history of past illness, personal and family history, physical examination, laboratory examinations, imaging examinations, final diagnosis, treatment, outcome and follow-up).

We have organized our manuscript using correct paragraphs (chief complaints, history of present illness, history of past illness, personal and family history, physical examination, laboratory examinations, imaging examinations, final diagnosis, treatment, outcome and follow-up).

4. The laboratory examination part could be more detailed, e.g., CRP, HgB, other important tests.

Examination after admission showed a white blood cell count of 4.6 × 109/L (75.4% neutrophils), red blood cell count of 5.29 × 1012/L, platelet count of 153.0 × 109/L, and C-reactive protein concentration of 25.2 mg/L. The prothrombin time was 10.9 s, activated partial thromboplastin time was 32.5 s, and international normalized ratio was 1.01. The blood urea nitrogen concentration was 9.2 mmol/L, the serum creatinine concentration was 84 μmol/L, and the alanine aminotransferase concentration was 39 U/L.

5. Do you have the primary ultrasound images of the inguinal B-ultrasound?

We have the primary ultrasound images of the inguinal B-ultrasound in Figure 1.

6. Do you have histological images?

We have histological images Figure 6

7. Please correct figure 4 – one of the terms is in Latin: "arteria iliaca externa."

We have revised the mistake of figure 4（external iliac artery）.

8. In the discussion part, I suggest summarizing the recommended surgical treatment options (whether or not to perform appendectomy) in a graphical way: a scheme or a table. This way, it would be clearer and more memorable.

Table 1 Surgical methods as determined by severity of appendiceal inflammation.

9. Please add DOI and PMID in the references part.

ORCID number: Min-Quan Yao 0000-0001-8567-9021; Bing-Hong Yi 0000-0003-0498-7204; Yong Yang 0000-0002-7785-8182; Xiao-Qi Weng 0000-0001-5194-3883; Jin-Xing Fan 0000-0003-2003-7858; Yu-Peng Jiang 0000-0001-9250-3606.

10. Please correct the text formatting errors.

The text formatting errors has been revised.

Reviewer #4: The authors present a detailed account of a De Garengeot hernia, with high quality images of the laparoscoopic procedure. The case is of scientific interest, but writing in the english language needs revision, particularly in the introduction and discussion sections.. It would be interesting to include what kind of antibiotic treatment was used and for what period of time. In figure 4, one of the subtitles is in portuguese (external iliac artery).

Writing in the english language has been revised.