Answering to reviewer's comments

Reviewer 1:

C: 1. The case reported a middle aged patient with a rare finding of meshoma with associated mesh infection followig mesh placement on account of recurring inguinal hernia. 2. The manuscript tried to highlight factors associated or responsible for mesh infection and meshoma with possible ways of preventing such. 3. Though the report tried to explain factors that might be responsible for meshoma formation and mesh infection, however more case may be needed for proper inference on the subject matter.

A: Thank you very much for your affirmation of this article. We really need more evidence to confirm the causes of delayed patch infection, and the research on the risk factors of meshoma formation is not sufficient. For ethical reasons, we are unable to conduct prospective studies to design meshoma, but rather retrospective analysis to identify risk factors for meshoma.

Reviewer 2:

C: 1. On page 5, line no. 4: Gastrointestinal bleeding was the final diagnosis, but was there melena? Or was FOBT positive called GI bleeding? If there was melena, was an endoscopy performed before surgery?

A: Thank you for your valuable comments on this manuscript. The patient has a positive fecal occult blood test but no melena. Regarding the diagnosis of gastrointestinal bleeding, we are based on the results after surgery, during which it was found that the mesh eroded the small intestine intestinal tube, and after the operation, we reviewed the fecal occult blood test and was negative, and gastroscopy and colonoscopy were performed respectively and no abnormal lesions were found. Therefore, we suspected that the gastrointestinal bleeding was caused by the meshoma eroding the intestinal tube.

C: 2. On page 6, line no. 2 Is the surgical site accessible by upper

gastrointestinal endoscopy? Isn't it a double-balloon enteroscopy? If you have endoscopy photos before/after surgery, it would be good to attach them.

A: We do not have double-balloon enteroscopy, and conventional upper gastrointestinal endoscopy cannot reach the lesion site. We performed gastroscopy and colonoscopy after surgery. In view of the large number of gastrointestinal examination sites, pictures of a single site cannot illustrate the entire gastrointestinal tract, so endoscopic pictures are not added to the article, if necessary, we can anonymize the endoscopy report and add it to the supplementary material of the article.

C: 3. On page 7, Figure 2 >Blood glucose level seems to improve as time passes after hospitalization. It is unclear whether this is due to the improvement of the condition due to the elimination of infectious causes after surgery or the improvement due to frequent blood glucose measurement and thorough use of drugs after hospitalization. If the authors want to talk about the improvement of blood glucose level by removing the infectious cause, it would be better to add the changes in HbA1c before and after surgery along with the drugs used for diabetes treatment. >How about showing antibiotics used, CRP level change, and culture results?

A: The timing of changes in blood glucose levels is not described in our article. We used hypoglycemic drugs before operation, which have been described in the revised draft. We added Figure 2 only to illustrate that the patient had untreated diabetes, and the blood glucose level was controlled within a reasonable range before the operation.

The antibiotic we used before surgery was Cefoperazone Sodium and Sulbactam Sodium which was changed to moxifloxacin according to the results of drug sensitivity test after the operation. The drug sensitivity of this patient was sensitive to penicillin, moxifloxacin, vancomycin and tegacyclin, except for tetracycline and clindamycin. This drug sensitivity result has been added to the revised manuscript. CPR decreased significantly after antibiotic

treatment before operation, and the result was close to normal，but there was a temporary increase after surgery. We considered that the patient had undergone surgery, which resulted in tissue damage, and it could not completely explain the existence of real infection, so the change level was not included in the text.

Reviewer 3:

I congratulate the authors for their case report. it is very well written, and presents a very care but serious complication of hernia repair with mesh. I suggest few minor changes: I don`t understand the meaning of "ileocecal canal" do you mean near the ileocecal junction? please rephrase abstract: background- I suggest to change It is rare to form a meshoma and erode the small intestine due to the curling of the mesh into meshoma formation and erosion to the small intestine is rare... curling - to folding ... that was not treated early, causing it to displace and erode the small intestine, WITH infection. complete control of symptoms WAS ACHIEVED after removal of the infected patch MASS, no recurrence of hernia AFTER 2 YEARS OF FOLLOW-UP CASE SUMMARY A 62-year-old male patient PRESENTED WITH recurrent abdominal pain repeatedly for 1 week, which has worsened 2 days BEFORE ADMITION, accompanied by fever. 5 YEARS BEFORE PRESENTATON HE UNDERWENT right inguinal hernia Plug and patch REPAIR approach. Two years ago, a CT scan revealed a right lower abdominal mass with soft tissue density, measuring approximately 30×17 mm, which was diagnosed as meshoma THAT WAS NOT TREATED. The patient HAD POORLY CONTROLLED DIABETES in the past year. introduction: sensitive antibiotics- please deleate sensitive treatment - replace autopsy with specimen`s pathology (also in Figure 3e) add culture results (it is only mentioned in discussion discussion: it is very informative and interesting but I think that since it is only a case report that the recommendations for the

mesh placement should be rephrased and emphasized it is the literature`s: for example- there are several recommendations in the literature to reduce the risk of meshoma formation. first choosing the right typs of mesh... conclusion: because it is only a case report and there is no data regarding the tecnique of th plag and patch repair, I think it is best to deleate th suggestions of avoiding folding and so on. focus on the fact that it is rare, and that if not treated in time it might erode and require resection of the involved organ.

A: Thank you very much for your detailed and specific review comments. I would like to reply to this as follows: First, admit an error that the expression "ileocecal canal" is inaccurate, it is actually "ileal canal", and it has been modified accordingly.

Secondly, we carefully revised the summary section after referring to the comments. The original of the patient's pathological report is in Chinese, so we were worried about adding the picture directly to the text. So we added the patient's pathological report to the supplementary material attached to the article after anonymous processing at the beginning.

Finally, after carefully reading the comments, we agreed that the suggestion of grid placement should be restated and emphasized, so we made corresponding modifications in the revised version and added new references. At the same time, the drug sensitivity results of this patient have been added. Indeed, this is only a rare case report. We cannot directly confirm the risk factors of meshoma formation, and more evidence is needed.

We hope it will be enough for your publishing policy.