Peer Review File

Article information: https://dx.doi.org/10.21037/dmr-22-61

Reviewer A

Comment 1: Please describe whether there have been any reported cases of Boerhaave syndrome from GEJOO in the Discussion.

Reply 1: There are case reports describing Boerhaave syndrome secondary to GEJOO from an esophageal malignancy, however given our patient did not have any malignancy, we will not discuss those reports.

There was one case report that described Boerhaave syndrome secondary to a gastric volvulus, which classifies as a GEJOO. We have briefly described this report.

Changes in the text: Lines 145-150. "Another published case describes Boerhaave syndrome secondary to benign gastroesophageal junction outlet obstruction. In the case report they describe an elderly female who presented with a gastric volvulus as the cause of the esophageal rupture. The patient underwent surgical drainage and irrigation of the mediastinum and pleural cavities, followed by a gastrostomy to fix and decompress the stomach. The patient was discharged after an uneventful hospital course."

Comment 2: Is there a term Boerhaave type esophageal rupture (Line 1, 51)? Isn't it actually Boerhaave syndrome?

Reply 2: Corrected

Changes in the text: Line 1,46. "Boerhaave syndrome is a condition carrying high morbidity and mortality, necessitating emergency intervention".

Comment 3: Insert arrows or arrowheads on the part of the abnormal findings in the all Figures.

Reply 3: Completed

Changes in the text: Arrows added to figures

Reviewer B

Reporting Checklist

Comment 1: Item 2. Please add "case report" as a key word in this manuscript

Reply 1: Case report has been added as a keyword

Change in text 1: Case report added as a keyword

Comment 2: Item 3b. Add patient's main diagnosis, interventions, outcomes and follow-ups to the "Abstract-CASE PRESENTATION" section.

Reply 2: Correction has been added in abstract lines 27-36

Change in text 2: The patient was ultimately diagnosed with a distal esophageal perforation with isolation to the intra-abdominal space. He was taken urgently to the operating room where the decision was made to proceed with a laparotomy. The perforation was repaired primarily with suture, followed by a myotomy and reinforcement of the repair with a loose 360-degree fundoplication. A gastric feeding tube was placed to allow for initial decompression in the early postoperative period, with plans to start tube feedings on postoperative day two.

During the recovery period, the patient progressed well and was ultimately discharged to home on postoperative day nine. He subsequently followed-up in clinic on postoperative day 22, at which time is gastrostomy tube was removed.

Comment 3: Item 3c. Describe in the Abstract-Conclusion the main take-away lessons, the clinical implications, or potential implications.

Reply 3: Added to abstract in line 44-46

Change in text 3: Gastroesophageal junction outlet obstruction should be considered when a patient presents with a rupture of the esophagus and abnormal esophageal anatomy on imaging. This will allow for potential incorporation of myotomy and fundoplication in the surgical repair.

Comment 4: Item 11a. Discuss limitations of the study in the discussion.

Reply 4: We describe the limitations in our report, under discussions, lines 117-121 "Our patient, in extremis, was unable to undergo formal esophageal testing, therefore the strong clinical clues—food bolus episodes in the past, “bird’s beak” type of LES narrowing and esophageal dilation and tortuosity upon presentation—were utilized to plan for immediate surgical remedy that would also accommodate for longer term recovery."

Change in text 4: No change completed. Our limitation was our inability to complete formal esophageal testing to diagnose GEJOO.

Comment 5: Item 11d. As mentioned in comment 3, summarize the main take-away lessons

Reply 5: Added to line 135-137 in the manuscript

Change in text 5: Gastroesophageal junction outlet obstruction should be considered when a patient presents with a rupture of the esophagus and abnormal esophageal anatomy. This will allow for potential incorporation of myotomy and fundoplication in the surgical repair.

Comment 6: Item 13. Specify "Written informed consent was obtained from the patient." in the manuscript

Reply 6: Added to manuscript in lines 18-19

Change in text 6: Written informed consent was obtained from the patient.

Comment 7: Change "Introduction" to "Background" in the abstract

Reply 7: Change in line 6

Change in text 7: Background

Comment 8: Suggest to remove "Discussion" section in the Abstract

Reply 8: Removed lines 38-45

Change in text 8: Discussion section removed from Abstract.

Comment 9: Case presentation was misspelled in the abstract

Reply 9: Case presentation was change and is now spelled correctly in line 19 of the abstract

Change in text 9: Case Presentation

Change 10: Change format of citations as described in Author instructions

Reply 10: All citations are already listed in the order as described in the author instructions (Authors; Year; Dataset title; Data repository or archive; Version (if any); Persistent identifier (e.g. DOI)

Change 10: No change was completed as all citations are already listed in the order in which the journal requests.

Change 11: "Patient's" is misspelled in the Abstract-Introduction

Reply 11: "Patient's" is spelled correctly in line 13

Change 11: No change made as "patient's" is spelled correctly.

Change 12: Add figure legends to figures 1-4

Reply 12: Figure legends at to figures 1-4

Change in text 12: Figure 1: "Coronal CT indicating a tortuous esophagus". Figure 2: "Coronal CT indication free intra-abdominal air surrounding the distal esophagus". Figure 3: "Axial CT indicating free intra-abdominal air surrounding the esophagus and a small right pleural effusion". Figure 4: "Water-soluble contrast study indicating no extravasation at repair site and normal esophageal morphology."