Peer Review File

Available at http://dx.doi.org/10.21037/pm-20-113

Comment 1:
While there is a clear definition for KD, are there similar criteria for case definition of MIS-C? Can the authors please include, if any. This is important, as it defines the accuracy of diagnosis of a relatively new condition.
Respond 1:
The criteria for case definition of MIS-C is also what we're concerned about. After consulting related literature, we found 3 case definitions of MIS-C by RCPCH, CDC and WHO. In the manuscript, we mentioned it in the second paragraph of Introduction (page 2, line 24). As it is very important, we revised the manuscript and listed the case definition proposed by WHO in brief (page 2, line 27)

Comment 2:
There should be some discussion as to the risk of over- and/or under-diagnosis of this condition, either through lack of knowledge/diagnostic tools or resources.
Respond 2:
Thanks for your suggestion. There is indeed a risk of insufficient diagnosis due to lack of relevant knowledge, which matters a lot in clinical practice. We added related discussion in the part of conclusion (page 7, line 28).

Comment 3:
For section on Pathogenesis, there are 2 long paragraphs. Consider simplifying or splitting the long paras up to make for easier reading. Should this part come after "clinical findings"?
Respond 3:
We rearranged the section on Pathogenesis. The two paragraphs were streamlined and merged. And we put them after "clinical findings" (page 6, line 3).

Comment 4:
As regards "Treatment", not much is known about optimal treatment for MIS-C while a good deal has been studied for KD. Could the authors postulate how or what other drugs/treatment modalities may be useful? Would the use of IVIG, glucocorticoids, infliximab etc work in MIS-C based on what authors describe as pathogenesis for this condition?
Respond 4:
All the drugs (IVIG, glucocorticoids, infliximab etc) work by stopping the inflammation. As the cytokine storm is fiercer in MIS-C, we wrote that "it is recommended to adopt a more aggressive treatment regimen in MIS-C" (page 6, line 29) and we listed the drugs that may be useful (page 7, line 1).

Comment 5:

Since a high incidence of coronary involvement in MIS-C has been reported, the authors should discuss the use of anti-platelet, anti-coagulants.
Respond 5:
Thanks for your advice. We added the content of anti-coagulant therapy in the revised manuscript (page 7, line 9).

Comment 6:
Also comment on how vaccines may change the picture of MIS-C, as another this is another area of extreme current interest.
Respond 6:
This is a good question. In clinical practice, we observed that a part of KD patients developed after injection of some vaccines, which indicates that the vaccine may be the trigger inducing immune dysfunction of KD. As for MIS-C, the coverage of COVID-19 vaccine may reduce the incidence of MIS-C by preventing the infection of COVID-19. However, it may also act as a pathogenic agent that induces the incidence of MIS-C. Therefore, we didn't mention the relevant content in our manuscript.

Comment 7:
Finally, the paper ends abruptly. Perhaps “Summary” can be padded up to end more smoothly into a nice “Conclusion”
Respond 7:
We rewrote the content of “Summary” and named it “Conclusion” (page 7, line 27).