Peer Review File

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Comment 1:

Reviewer A

Well-written.

What medications what was the patient on for CKD? What was the cause of her CKD?Was vasculitis excluded?

Sometimes, atrophic punctate scars are present in between the reticulate hyperpigmentation. (ref: Khaitan BK, Ahuja R. Erythema Ab Igne. N Engl J Med. 2022 Oct 6;387(14):e33.)

Reply 1:

We appreciate your review. The patient's medication for CKD are Furosemide 40 mg once a day and Empagliflozin 10 mg once a day.

The patient has a stable CKD G3bA3 (KDIGO) diagnosed in 2021, whose kidney biopsy revealed mesangial proliferative glomerulonephritis with immune deposits and blood tests presented ANA +(1/100).

In the moment of presentation of the skin lesions, we did not proceed further investigation as Erythema ab igne is a clinical diagnosis and the patient lesions resolved gradually.

Changes in the text: Not applicable

Comment 2:

Reviewer B

Beautifully written report and illustration of erythema ab igne. I would only add a brief dermatological description before mentioning the presence of posterior tibial artery and dorsalis pedis artery pulses- to emphasise the reticulate vascular appearing pattern on the skin - key clue for a visual diagnosis.

Any references to be included?

Reply 2:

We appreciate your review and we agree with the changes on the text, described below. This kind of manuscript (image in clinical medicine) does not comprise the mention of references. However, we have used these articles below:

- Beleznay K, Humphrey S, Au S. Erythema ab igne. CMAJ. 2010;182(5):E228
- Adams BB. Heated car seat-induced erythema ab igne. Arch Dermatol.

2012;148(2):265-266
- Abasszade JH, Abrahams T, Kuan CC, et al. Erythema Ab igne. BMJ Case Reports CP 2023;16:e255308

If you consider it's important to mention the references, we can add them to the manuscript.
Thank you so much once again for your review.

Changes in the text:
We have modified our text as advised (see Page 1, line 6) "On physical examination were seen hyperpigmented, brownish, web-liked patches spanning across the inner and posterior faces of both thighs (**Figure 1**), more evident on the left (**Figure 2**). Posterior tibial artery and dorsalis pedis artery pulses were normal, there were no areas of necrosis and no purpura or subcutaneous nodules were palpable."