Peer Review File

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Reviewer A:

- Comment 1: In the CT scan the level of the arrow is jejunojeunostomy and not gastrojejunostomy as presented in the manuscript. It sounds like the authors were not sure of the diagnosis. If this was truly a candy cane syndrome of Gastrojejunal anastomosis it should have been evident on upper GI series. The arrow is right next to the staple line of jejunojejunostomy clearly the lesion in question is far lower down than the gastrojejunal anastomosis. It appears there was a blind loop of biliopancreatic limb of Jejunojejunostomy and not a gastrojejunal candy cane.
- Reply 1: We have modified our text as advised. It was a mistake due to miscommunication with the surgeon in charge. "Jejunojejunostomy" was misheard as "Gastrojejunostomy" in our first meeting which, unfortunately, we based our case-report on. But thanks to your enlightenment, we have conducted a full review of the operative notes in detail, and it is an obstruction in the jejunojejunal junction rather than the gastrojejunal junction. as what you have kindly suggested,
- Changes in text: The case report has been reviewed again from scratch, and all the words "gastrojejunal junction / gastrojejunostomy" were replaced with "jejunojejunal junction / jejunojejunostomy" as needed.

- Comment 2: The resection could have been carried out laparoscopically, not sure why it was converted to laparotomy.
- Reply 2: Reason why it was carried out as a laparotomy is because the surgeon did a diagnostic laparoscopy at first, but it showed an large amount of adhesions (due to the multiple surgeries the patient had in her past as clarified in the case report), upon which adhesiolysis was carried out, but it was still very difficult to carry out the operation laparoscopically and the surgeon felt it might be risky due to the large amount of intra-peritoneal adhesions, therefore, the operation was carried out as a laparotomy.
- Changes in text: Further details have been included (Page 4 L93 – L97).

- Comment 3: Technique of resection of candy cane is not well described. One should not just fire a stapler across the GJ anastomosis until there is a bougie of a endoscope across the GJ anastomosis into the proximal roux limb for fear of narrowing the GJ.
- Reply 3: The technique is as follows. Laparoscope → Adhesiolysis → Mini-Laparotomy → Resection of an obstructed/dilated piece of small bowel (measuring ~14 cm).
- Changes in text: Further details have been included (Page 4 L93 – L97).

- Comment 4: Candy cane of the Gastrojejunal anastomosis does not present with SBO, rather it presents with SBIO. On the other hand, candy cane of jejunojejunostomy can present with SBO.
- Reply 4: As already mentioned in reply 1 for comment 1, it is a case of CCS at the jejunojejunostomy rather than gastrojejunostomy, therefore, SBO symptoms can be explained.
- Changes in text: Gastrojejunostomy and its related meanings were modified to jejunojejunostomy and its related meanings.

Reviewer B:

- Comment 1: need more surgical details about the initial gastric bypass and the revision surgery.
- Reply 1: We have tried obtaining details about the first gastric bypass and the second gastric bypass (revision surgery) from the patient in the past 3 weeks. But the patient has done each surgery in a different hospital, and she doesn't have a copy of her surgical report. Our team has tried contacting the hospital in charge, but they refused to provide us with any information due to confidentiality protocols, as the patient is the only one who has the right to obtain another copy of her surgical reports.
- Changes in text: No modifications made.