Dear editors,

We are thankful for the continuous support and guidance with the critical reviews of our manuscript. The reviewer's comments were constructive and have inspired us to make our manuscript more systematic and error free. The suggested changes were very insightful and pinpointed our errors. We have tried to edit as per the suggestions and have finalized the manuscript. We have made the following changes in our manuscript as per the suggestions from our reviewers.

REVIEWER 1:

1) Page 2, 1st paragraph, line 8: I would like to know why rescue took so long? As in many underdeveloped nations we suffer from a significant lack of resources and stable government leadership. We lack reliable internal infrastructure in terms of transportation due to lack of funding for roadways, vehicles and communication systems. The natural rugged landscape compounds these problems. Further there are not many large hospitals capable of caring for trauma patients in regions outside of major cities. Difficult access to the rescue team? Incipient trauma system? Also, what kind of trauma care was provided at the scene? How patient was transported in the ambulance? Supine position? I need more details on this.

SUGGESTIONS ACCEPTED AND CHANGES MADE AS" Bystanders who witnessed the injury kept him immobile in supine position. EMS personnel in Nepal are only beginning any specialized training beyond basic assessment and transfer so further interventions such fluid resuscitation and oxygen administration were not performed on scene or enroute. Further, due to the poor internal infrastructure as a result of financial and political instability in Nepal as well as the native rugged terrain, the child had a prolonged transport time of approximately 3 hours."

2) Page 2, 1st paragraph, line 3: I am curious to know the neck zone of the trauma injury. In this case you should add zone 1.: SUGGESTION ACCEPTED
3) Page 2, 2nd paragraph, line 3: At this point in the ED you should have minimal idea about what kind of internal injuries this patient have. However, he has clinical signs of shock (ATLS shock classification grade iii due to decreased systolic blood pressure mainly). This could be hemorrhagic shock, cardiac tamponade or a hypertensive pneumothorax, for instance. Plus the fact that the patient was saturating low. It isn't clear to me why you did send an unstable patient with an obvious penetrating thoraco-abdominal injury to the CT scan. Also, why not intubate a patient that is unstable and desaturating? Another question, are you sure that abg’s were normal? After 3 hours of the accident, hypotensive, hyper ventilating and saturating 86%? These don’t look right.

: SUGGESTION APPRECIATED: The patient was unstable at Triage station. Two wide bore intravenous catheters were placed, and a bolus of 2 liters of normal saline was administered immediately for fluid resuscitation, as the patient appeared to be in shock. The team of on call surgeons, anesthetists and radiologists were summoned immediately. After aggressive fluid resuscitation a blood pressure of 118/60 mm of Hg with pulse of 70 BPM was obtained and oxygenation was maintained, so we elected to proceed to imaging for better surgical planning. He was accompanied by the ED, surgery and anesthesia colleagues to the radiology room, being monitored in real time. Again, the patient was hemodynamically stable and no haemothorax or pneumothorax was noted, so we proceeded with CT and deferred intervention such as chest thoracostomy. Noticeably, the ABG reports were normal which is interesting.

4. Can you explain the reason for not intubating the patient in the ED, since he was saturating in 86%? :Suggestion accepted as " He was place on air mask at 5L/min after admission in the ED and resuscitated with fluids, which improved oxygenation immediately to 96%. (Because saturation was maintained, the surgical team preferred to defer to proceed with chest thoracostomy until in the operating suite."

5. Page 3, 1st paragraph, line 5: Please explain why you send an unstable Patient to the CT Scan? Was the CT Scan truly necessary? Please add comments / explanations.: Suggestions accepted as"

The patient was stable before taken to the radiology suite ; if unstable after initial resuscitation the patient would have been transferred to the operating suite."

6) Page 3, 2nd paragraph, line 2: Please insert AAST-OIS grade for bowel injuries.: suggestion accepted and grading of bowel injuries inserted for colonic and intestinal injuries

7) Page 3, 2nd paragraph, line 3: On the CT scan slices it does not look the pylorus was injured, but the large curvature of the stomach - make sure this
information is correct.: The information is corrected by the surgical team and suggestions accepted as": The bamboo stake has penetrated through the front posterior wall of stomach near greater curvature at body, cardia, and then through the diaphragm."

8) Page 4, 2nd Paragraph, line 5: Do you have "fresh whole blood" available at your institution? This is not exactly common nowadays in most hospitals worldwide, unless you are at war-scenario. Please detail. : SUGGESTON ACCEPTED AS "We have a system of on demand fresh blood products in the hospital in case of extreme emergencies from donors within the hospital premises".

9) Page 4, 3rd paragraph, line 1: You started giving ceftriaxone and metronidazole in the ed. Why changing the antibiotics in a couple of hours? Meropenem is an ultra-broad spectrum injectable antibiotic used to treat a wide variety of infections. It is a beta-lactam and belongs to the subgroup of carbapenem, similar to imipenem and ertapenem.

Trading antibiotics with no clear indications could lead to antibiotic resistant infections. Please make this clear: SUGGESTION ACCEPTED

Ceftriaxone, metronidazole and tetanus vaccination were administered as per ED protocol for emergent surgeries. The child was kept on mechanical ventilation for 36 hours with intravenous antibiotics meropenem and clindamycin added by the ICU team to offer increased antibiotic coverage as there were concerns for contamination from organic matter as well as intraabdominal contents secondary to hollow viscus injury. Moreover, meropenem is ten times more expensive than the initial combination used and was provided free of cost by the hospital noting this extraordinary injury.

10) Page 10, 4th line: Needs further discussion on damage control resuscitation: Suggestion accepted as" Damage control resuscitation appears to be the new mantra in the advanced care of penetrating trauma. This integrated approach warrants that resuscitation and surgery are undertaken simultaneously, with close communication and cooperation between surgeon and anesthetist. We had no reason to choose a DCR as our patient had no to acidosis, hypothermia nor was unstable."

11) There are several typo mistakes. Please make sure you have all them corrected.: SUGGESTION ACCEPTED AND ALL CHANGES MADE We apologize for these avoidable mistakes.

12) Number manuscript pages.: SUGGESTION ACCEPTED AND ALL CHANGES MADE

13) Reference list is with some typo and font text mistakes. It looks like you copied and pasted from another place. Please make sure you have all them corrected.: SUGGESTIONS ACCEPTED and The references are adjusted according to the journals instructions.
14) See the PDF bellow for more minor corrections: All the other minor corrections has been made in the pdf. The suggestions are appreciated.

REVIEWER 2:

1. The paper is far too long for a case report.: Suggestion accepted and We have tried to delete the redundancies and shortened the discussion.

2. The authors should concentrate on the relevant facts. We do not need to know that an alcohol test was done in a thirteen-year old, nor of all the other myriad tests which, by report, were normal. Suggestion accepted and the list of normal tests deleted.

3. The introduction includes statements that should be in the discussion.: Suggestion accepted and the statements brought down to the discussion.

4. There are too many illustrations.: Suggestions accepted and The illustrations has been decreased to just the important ones.

5. Did the bamboo stake include a nail or screw? I was not aware that coconut trees existed in Nepal.: Suggestions accepted and Yes, the bamboo stake has a screw which has now been mentioned as "A bamboo stick with an iron nail (seen in the abdominal X-ray adjoining the stomach silhouette in Figure 2.) approximately 50 centimeters in length,". The nails were in the bamboo stake as the bamboo stakes were fixed by nails to make a fence. Also, coconut trees are common the hilly and terai regions of Nepal.

Thanks again for reviewing the document and passing the wonderful comments. It has been a great learning experience working with the team.

Regards,

GM, BB, RV, CH, SA, AB