Peer Review File

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Reviewer A

Thank you for this case report.

1) This is a well known phenomenon for atypical chest pain, please describe more of the presenting symptoms? There was no gagging, vomiting, retching at all?
Reply 1: The patient did not experience any episodes of vomiting or retching prior to the onset of symptoms.
Changes in the text: We added "there was no history of gagging, vomiting, or retching prior to the onset of symptoms." in the Case presentation section. See Line 88-89, page 4.

2) Patient a good historian, from nursing home?
Reply 2: The patient was living with his daughter. The medical history was obtained from both the patient and his daughter upon admission.
Changes in the text: We added the information in the Case presentation section. See Line 92-93, page 4.

3) ETOH and tobacco history? Overall, tough case, with exsanguination due to severely delayed diagnosis.
Reply 3: The patient had no history of smoking but reported a 40-year history of alcohol consumption, averaging two bottles of beer and approximately 100 mL of liquor per day. The background was introduced in the original manuscript. See line 89-91, page 4.

Reviewer B

The authors presemt an interesting report of esophageal perforation mimicking AMI. The text is generally well-written and the experts`s comments are also of great value.
We appreciate your positive feedback.

Comment 1: I would consider including a chest radiograph, if available. It would be interesting to see if any radiological sign of perforation was present.
Reply 1: Although the D-dimer was negative, we still could not rule out esophageal rupture or aortic dissection. Therefore, we decided to proceed directly with an aortic enhanced CT scan without performing a chest X-ray.

Changes in the text: We added the information in the Case presentation section. See Line 127-130, page 5.

Comment 2: Figures 1 and 2 could have better quality. I suggest scanning and improving the images.

Reply 2: Unfortunately, these are the highest quality images available from the hospital's electronic medical record system. I am afraid that further processing will decrease the quality of the images.

Reviewer C

Well written case report.

Thank you for your encouraging comments.

Reviewer D

The authors presented clearly and concisely a case report of esophageal perforation mimicking acute myocardial infarction. Given the seriousness of the two conditions, and the topic deserved relevance despite the rarity of this presentation, this manuscript helps to raise awareness about it. The discussion very clear and the experts' opinion very pertinent and informative.

Your positive assessment is much appreciated.

Comment 1: I do believe though the authors should present a more details regarding this case such as: Any other information on this patient that could shed light as to why the perforation went undiagnosed initially?

Reply 1: The patient's initial presentation of acute chest pain without nausea or vomiting, combined with ECG changes suggestive of acute inferior wall myocardial infarction, led to the activation of the acute coronary syndrome protocol. This approach was appropriate given the presenting symptoms and ECG findings.

Comment 2: Was there an autopsy performed? was it a foreign body ingestion or perforated cancer or secondary to vomiting? I think this additional information would be very helpful for the reader to achieve a better understanding of the topic.

Reply 2: Unfortunately, the patient's family declined an autopsy. We initially suspected foreign body ingestion, but the patient’s family member denied this possibility. The patient's long-term history of alcohol consumption reminds that it’s more likely a case of spontaneous perforation.

Changes in the text: See Line 145-148, page 6.

Reviewer E

The authors present an interesting presentation of esophageal perforation mimicking an acute coronary event. Given there have been very few case reports describing this phenomenon the report will be a useful narrative in maintain a broad differential for chest pain. However, the reporting of the case can be improved.

Comment 1: The authors state that the perforation in this case was caused by foreign body ingestion. How did the authors come to this conclusion? It would also be notable to provide timelines from presentation to investigation and subsequent death. This provide insight into how rapidly the patient was deteriorating. The only vitals provided indicate the patient was normotensive and afebrile. It's unclear why the patient would suddenly exsanguinate and die.

Reply 1: We apologize for the confusion. While we initially suspected foreign body ingestion, further review of the patient's history suggests this was more likely a case of spontaneous esophageal perforation. The patient's long-term history of alcohol consumption is a known risk factor for spontaneous perforation. Unfortunately, without an autopsy, we cannot definitively determine the exact cause. We have corrected this in the revised manuscript and added a discussion on the potential etiology.

Changes in the text: In Discussion section, we added "We initially suspected foreign body ingestion, but the patient's family member denied this possibility. The patient's long-term history of alcohol consumption reminds that it's more likely a case of spontaneous perforation. Unfortunately, without an autopsy, we cannot definitively determine the exact cause." See line 145-148, page 6.

Comment 2: Additionally, did the CT rule out aortic dissection? I have personally had a case of aortic dissection causing esophageal ischemia and perforation given the aortic perforators provide the blood supply. The authors should also expand on what the etiology of this perforation was. It is very unusual to have a spontaneous mid esophageal rupture.

Reply 2: Yes, the enhanced CT scan of the aorta ruled out aortic dissection. We appreciate your sharing of the case of aortic dissection causing esophageal ischemia and perforation. In our case, the CT findings were more consistent with primary esophageal perforation rather than secondary to aortic pathology. See line 126-130, page 5 in the manuscript.

Comment 3: Additionally, a more complete past medical history should be provided of the patient. The normal lab values should be provided in brackets besides any values stated. The chest x-ray on initial presentation may also be provided if there were any suspicious findings (eg pneumomediastinum, pleural effusion, etc).

Reply 3: Thank you for your valuable suggestions. We have addressed your points as follows:

Regarding laboratory values, we provided normal reference ranges in brackets next to all reported laboratory values.

We have added a more complete past medical history in the Case presentation section. Changes in the text: See line 88-93, page 4.

We have provided normal reference ranges in brackets next to all reported laboratory values. Changes in the text: See line 120-124, page 5.

Regarding the chest X-ray, we did not perform an initial chest X-ray as we proceeded directly to an enhanced CT scan. We have explained this decision in the manuscript. Changes in the text: See line 127-130, page 5.

Overall, this paper may be suitable for publication after the above issues are addressed.