Dear Editors of *World Journal of Clinical Cases*

We appreciate your kind and instructive comments for our submitted manuscript (No: 55971, Title: "Bronchial glomus tumor with calcification: A case report and literature review"). Following the comments from the one reviewer and the editorial office, we revised our manuscript, and our replies to the comments are showed as follows.

Responses to the comments from Reviewer #1:

This is a rare case and can be quite informative to the readers. The manuscript is concise, well-written. There are some typographic errors. I encourage the authors to read the manuscript thoroughly before resubmission. The case presentation must be one paragraph. I suggest to combine all clinical, imaging examinations, laboratories results in one domain.

In reply:

Thanks for your kind suggestion, we regret for the typographic errors. We have read the manuscript carefully again and corrected them. We would like to make the case presentation into one paragraph, and combine all clinical, imaging examinations, laboratories results in one domain. But the "World Journal of Clinical Cases" web page does not allow it. We have submitted a manuscript formatted according to your suggestion (in Supplementary Materials). At the same time, we summarize the clinical and pathological data of the patient in **Table 1**.

The World Journal of Clinical Cases web page as follows:

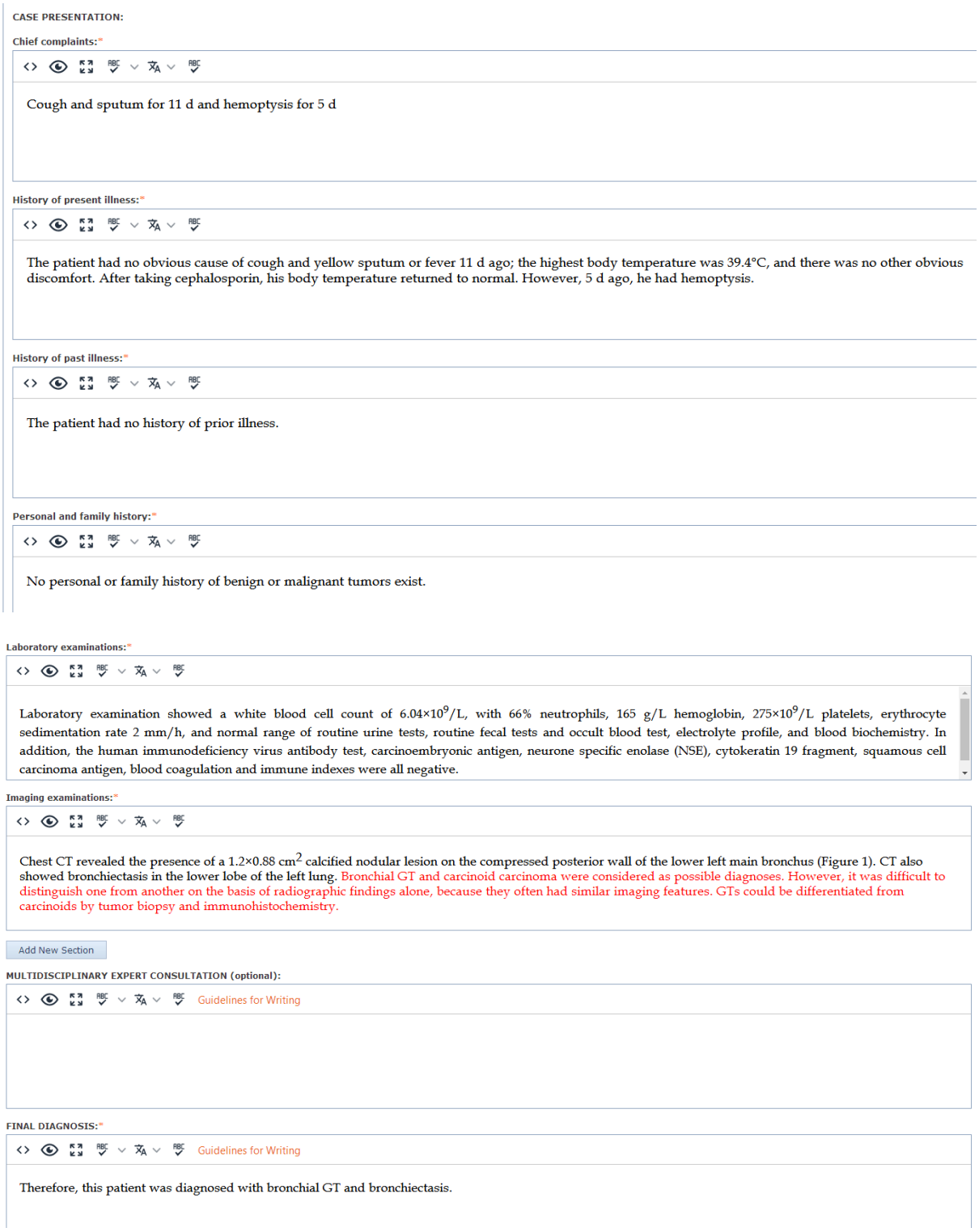

Table 1. Clinical and pathological data of the patient

Project	Content
Biographical data	33-year-old man
Family history	No

Personal or family history	No
Chief complaint	Cough and sputum for 11 d and hemoptysis for 5 d
Physical examination of the lung	Normal except for vesicular breath sounds
Chest computed tomography	1.2×0.88 cm^2 calcified nodular lesion was found on the compressed posterior wall of the lower left main bronchus (**Figure 1**). Bronchiectasis in the lower lobe of the left lung was found.
Fiberoptic bronchoscopy	Yellow–white, slightly hard mass was found obstructing the entrance to the basal segment of the lower left lobe (**Figure 2**). Neoplasms with multiple nodular ridges and superficial hyperemia were observed in the lateral to the entrance of the basal segment of the lower left lobe (**Figure 2**). Mucosal biopsy using a fiberoptic bronchoscopy is prone to bleeding.
Pathology	Microscopically, the tumor cells were uniformly round with smooth nuclear contours, fine chromatin and a modest amount of pink cytoplasm. They were arranged in sheet-like patterns between small blood vessels (**Figure 3A**). Left main bronchial glomus tumor with immunohistochemistry results of SMA(+) (**Figure 3B**) and actin(+)(Figure 3C), CD56 (NK-1)(-), CgA(-), CK5/6(-), CK7(-), napsin-A(-), P40(-), TTF-1(-), CK(-), NSE(-), S-100(-) and Ki-67 (<1%), and Syn immunohistochemical staining was weakly positive.
Final diagnosis	Bronchial glomus tumor and bronchiectasis
Treatment	Conservative treatment. Piperacillin–tazobactam 4.5g twice daily and erdosteine 0.3g twice daily for 9 d.

	Intravenous administration of Agkistrodon 2U once.
Follow-up	Clinical follow-up for 25 mo showed that the patient has no symptoms.

SMA: Smooth muscle actin; CgA: Chromogranin A; CK5/6: Cytokeratin5/6; CK7: Cytokeratin7; TTF-1: Thyroid transcription factor-1; CK: Cytokeratin; NSE: Neurone specific enolase; Syn: Synaptophysin.

If you need us to modify the manuscript further, please notify me and I will make further modifications.

Thank you very much.

Best regards.

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