

Dear reviewers:

We are very grateful to you for reviewing the paper so carefully and providing very helpful comments to guide our revision. We have provided a point-by-point response below.

Reviewer #1:

1. The authors repeated in the text that the BC appeared later, please correct to was discovered later.

Response: We corrected the descriptions in relevant paragraphs.

In Case Summary, we changed “Unfortunately, she subsequently suffered from breast cancer, which was accompanied by ipsilateral supraclavicular LN metastasis 4 mo later.” to “Unfortunately, a breast cancer was discovered 4 mo later, which was accompanied by ipsilateral supraclavicular LN metastasis.”

In Core Tip, we changed the description “a second primary cancer of breast carcinoma” to “a breast carcinoma”.

In Discussion, we changed the description “metachronous cancers of PTMC and BC” to “cancers of PTMC and BC”

2. In the discussion, the description with so many details of the case report by Bruno is unnecessary, please summarize.

Response: We presented the core tip of the cases reported by Bruno now. Bruno *et al*^[4] reported a similar case of contralateral LN skip metastasis in Germany. However, those authors identified the unusual pathway of CLNM, mainly *via* the detection of high thyroglobulin levels in the wash-out liquid of fine-needle aspiration biopsy. In our case, it was mainly based on the postoperative immunohistochemical findings.

3. Focus on the difficulties in the diagnosis and the complication by BC. The conclusions are focused on the PTMC. In my opinion, the exact diagnosis is important to adapt an optimal treatment. The conclusion must be focused in the 2 tumors and not only in the thyroid. The aim of a case report is how to proceed in beneficial of the patient and not only to describe the diseases.

Response: We have adjusted the order of case presentation. In **DIAGNOSE**, we changed the conclusion “The initial diagnosis was lymphatic metastasis of PTMC. However, we could not exclude the possibility of contralateral lymphatic skip metastasis, and further postoperative pathologic confirmation was required” to “PTMC with contralateral lymphatic skip metastasis and BC with supraclavicular lymphatic metastasis.”

In **CONCLUSION**, we added our experiences in distinguishing the origin of CLNM when it comes to multiple cancers such as PTMC and BC.

Reviewer #2:

1. The histomorphological findings should be substantiated with immunohistochemistry. The positivity for thyroglobulin and the missing immunostaining for estrogenreceptor should be shown.

Response: We appreciate it very much for this good suggestion. In this article, we concluded that the lymph node in levels III and IV originated from PTMC. It was mainly based on the following immunohistochemical findings: positivity for galectin-3 and CK19, negativity for CD56, HBME-1 and thyroid peroxidase. The Ki-67 index was 1%. In malignant neoplastic thyroid lesions, galectin-3, HBME-1, and cytokeratin-19 were diffusely expressed in general. We agree with you that it would be more convincing if the positivity for thyroglobulin and the missing immunostaining for estrogenreceptor were shown, which could further confirm the CLNM in levels III and IV originated from PTMC instead of BC. However, it was a pity that the patient did not underwent this examination so we failed to present this data. Your suggestion reminded us to take more detailed immunohistochemistry examination when it comes to similar unusual CLNM in clinical practice. What's more, we added the immunohistochemical findings of the thyroid nodule in the right lobe which could be found in *Further diagnostic work-up*

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