Dear Lian-Sheng Ma,

Thank you very much for your review.
Here I attach the answers to all your comments and suggestions. We have already modified the manuscript, adding all the data you had kindly asked for. We make a point-to-point response to the issues as follows. The revised parts are underlined for easy identification.

SPECIFIC COMMENTS TO AUTHORS

Reviewer #1:
Scientific Quality: Grade D (Fair)
Language Quality: Grade A (Priority publishing)
Conclusion: Major revision
Specific Comments to Authors: In this paper authors describe a good outcome found in a patient affected of follicular lymphoma treated with anti CD20 rituximab. This is an interesting outcome based in the poor association anti-CD20 and SARS CoV 2 published Persisting SARS-CoV-2 viraemia after rituximab therapy: two cases with fatal outcome and a review of the literature Br J Haematol2020 Jul;190(2):185-188 Multiple sclerosis and the risk of infection: considerations in the threat of the novel coronavirus, COVID-19/SARS-CoV-2 J Neurol 2020 May;267(5):1567-1569 Although the description is clear, there are some issues that should be clarified: 1) Were the authors aware the SARS CoV 2 status in the patient prior to start the chemotherapy cycles? 2) What test were performed by the diagnosis of SARS CoV 2 by nasopharyngeal swab? Antigenic test? PCR test? Could it have been a false positive result in the test ? How they been able to rule it out? 3) Based in this case, would you recommend maintaining a possible treatment with rituximab in a cancer patient affected by Covid 19? In the literature it is advised to interrupt 4) Authors should discuss how can affect rituximab treatment by the success of possible future vaccine in the patient.

Comments: Thank you for the insightful editorial content and assessment, as well as contained critical remarks.

Issue 1: Were the authors aware the SARS CoV 2 status in the patient prior to start the chemotherapy cycles?

Response 1: Thank you for asking this question. Indeed, the above-mentioned information was not pointed out clearly enough in the manuscript. The authors were not aware of the patient's positive SARS-CoV-2 status prior to the scheduled immunochemotherapy administration. It was not until obtaining the results of the PET-CT scan, which was performed shortly before rituximab administration (being the first component of the R-CVP regimen) and revealed previously nonexistent pulmonary changes, potentially of infectious aetiology, that we decided to conduct the nasopharyngeal swab test, confirming the SARS-CoV-2 infection.

REVISION 1

Having regard to the current global epidemiological situation, on 01.10.2020 we extended the diagnostics, taking a nasopharyngeal swab to test for SARS-CoV-2, which led to a positive result. It means that the authors were not aware of the patient's positive SARS-CoV-2 status prior to the scheduled immunochemotherapy administration.

(Further diagnostic work up; Page 8; Line 5-7)

Issue 2: What test were performed by the diagnosis of SARS CoV 2 by nasopharyngeal swab? Antigenic test? PCR test? Could it have been a false positive result in the test ? How they been able to rule it out?

Response 2: The authors agree with the reviewer that, with no doubt, the matter under discussion is worth being clarified. The patient's SARS-CoV-2 status was confirmed by the genetic RT-PCR test, using a sample obtained from the nasopharyngeal swab. Taking into account the positive result as well as some major pulmonary changes

detected in the PET-CT scan, we were able to rule out the false positive result with great certainty.

REVISION 2

Having regard to the current global epidemiological situation, on 01.10.2020 we extended the diagnostics, taking a nasopharyngeal swab for SARS-CoV-2 RT-PCR test, which led to a positive result. In the light of the clinical picture, including especially the pulmonary changes detected in the PET-CT scan, the possibility of obtaining the false positive RT-PCR result was ruled out with great certainty.
(Further diagnostic work up; Page 8; Line 1-5)

Issue 3: Based in this case, would you recommend maintaining a possible treatment with rituximab in a cancer patient affected by Covid 19? In the literature it is advised to interrupt.

Response 3: Thank you for taking into consideration this highly significant issue. Based on the presented clinical case, we do not recommend maintaining the treatment with rituximab among the oncological patients infected with SARS-CoV-2, and the alleged literature states the same [10]. Described course of events was not a standard one and the rituximab-containing regimen was administered to the SARS-CoV-2 positive patient before having possessed the knowledge about its viral status. Nevertheless, rituximab is not believed to be a cause of the infection itself, as it probably had its beginning at home, prior to the succeeding hospitalization.

REVISION 3

From our point of view, this case report may be important, especially regarding patients with an oligosymptomatic course of COVID-19, but requiring urgent lymphoma treatment.

Presented course of events was not a standard one and the rituximab-containing regimen was administered to the SARS-CoV-2 positive patient before having possessed the knowledge about its viral status. Although the described case

report shows that rituximab-based therapy may have no evident negative effect on the clinical course of COVID-19 in the patients with FL, it should be remembered that the administration of cancer chemotherapy in patients with COVID-19 is associated with increased mortality and certainly further research is needed in order to learn the causes of distinct COVID-19 clinical courses in patients undergoing the same anti-CD20 treatment.

(Conclusion, Page 10 Line 4-7 and Page 11, Line 1-5)

Issue 4: Authors should discuss how can affect rituximab treatment by the success of possible future vaccine in the patient.

Response 4: Thank you for raising this crucial subject. According to Rubin L.G. et al., patients receiving rituximab, because of their poor immune response, generally should receive the vaccine ≥6 months after therapy. Our patient finished the main course of the treatment (6 cycles) and currently stopped maintenance therapy after receiving 2 injections of rituximab. The vaccination is planned for the early autumn. Hopefully, by this time she will have been vaccinated against COVID-19. We assume that the immune response to the vaccination will be comparable to the one developed in other same-aged patients with FL but with no history of COVID-19.

REVISION 4

Another important issue is how treatment with rituximab may affect the success of possible future vaccine in the patient. According to Rubin L.G. et al., patients receiving rituximab, because of their poor immune response, generally should receive the vaccine ≥6 months after therapy [26] and so should our patient.

(Discussion, Page 10, 3rd paragraph)

Update: Outcome and follow-up

Having reached a seronegative status along with no auscultation abnormalities, nor other physical examination findings, the patient successfully received 6 cycles of R-CVP regimen, after which next PET-CT scan was conducted and confirmed complete

remission (CR). Then maintenance treatment with rituximab monotherapy (R-mono) was implemented and at the time of this report our patient received 2 injections of rituximab.

(Outcome and follow-up, Page 9 Line 1-6)

Reviewer #2:

Scientific Quality: Grade A (Excellent)

Language Quality: Grade A (Priority publishing)

Conclusion: Accept (General priority)

Specific Comments to Authors: Well written manuscript. No further improvement required.

Comments: Thank you very much for the positive feedback of our manuscript.

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We appreciate very much your kind consideration for publication of our manuscript and look forward to hearing from you at your earliest convenience.

Yours sincerely,
Stanisław Łącki