

Dear Editors and Reviewers:

Thank you for your letter and for the reviewers' comments concerning our manuscript entitled "Extrapontine myelinolysis caused by the rapid correction of pituitrin-induced severe hyponatremia: A case report and review of the literature" (ID: 52972). Those comments are all valuable and very helpful for revising and improving our paper. According to your advice, we have made correction which we hope meet with approval. Revised portion are marked in red in the paper.

In addition, the language polishing fee of this paper comes from the grants of Department of Health, Zhejiang province, China. So, if permitted, we would like to add the information of funding. **"Supported by grants from the Department of Health of Zhejiang province, China. No.2016RCA013."**

The main corrections in the paper and the responds to the reviewer's comments are as following:

Reviewer 1:

The reviewer's comment:

1. "We stopped pituitrin therapy on day 5 since we considered pituitrin to be the main cause of his severe hyponatremia. However, on day 6, a sharp increase in the level of sodium (from 119 to 137 mmol/L, ΔNa^+ 18 mmol/L, serum osmolality of 288 mOsm/kg) was detected unexpectedly (Figure 1), accompanied by an obviously elevated urine output from 0.9 L to 2.1 L (Table 1). We stopped the hypertonic saline solution immediately. However, on the seventh day of admission, the patient developed sudden-onset generalized tonic-clonic seizures."

Please re-formulate the above paragraph: you cannot be astonished with what happens to your patient once and again, without foreseeing things.

2. Also, please do not use rare or exotic terms: hypermyotonia (replace with: exaggerated muscular tone) naupathia (??? I have never seen this term in any medical article)

3. When you say "The serum C-reactive protein was slightly elevated at 1.0 mg/dL"; please MENTION NORMAL RANGES OF YOUR LABORATORY.

The authors' Answer:

1. We re-formulate this paragraph as following:

On day 5, his serum sodium was 119 mmol/L. Then, we stopped pituitrin therapy since we considered pituitrin to be the main cause of his severe hyponatremia. On day 6, the serum sodium level rose to 137 mmol/L ($\Delta[\text{Na}^+]$ 18 mmol/L), accompanied by an obviously elevated urine output from 0.9 L to 2.1 L. Unfortunately, on day 7, the patient developed sudden-onset generalized tonic-clonic seizures. After the seizures were controlled by intravenous diazepam, the neurological symptoms worsened over the following days, presenting as severe dysarthria and movement disorders. He was unable to speak, write and walk. The changes of the patient's serum sodium during pituitrin treatment and correction of hyponatremia was shown in Figure 1.

2. We have changed the word "naupathia" to "nausea" and replaced "hypermyotonia" with "exaggerated muscular tone".

3. We have added the normal range of serum C-reactive protein. (normal range < 0.8 mg/dL)

We appreciate for editors' and reviewers' warm work earnestly, and hope that the correction will meet with approval. Once again, thank you very much for your comments and suggestion.

Best regards,

Liang-jie Fang and Zhi-jie Pan

2020.1.4