Answering Reviewer

Dear Editor:

Thank you for your email dated January 29, 2021, which contained the editorial and reviewers' comments. We have carefully reviewed each comment and provided our point-by-point responses to each comment as below.

Reviewer 1

1. Why don't use the authors fine needle aspiration biopsy before the open biopsy. In general, the open biopsy is used as last method for diagnosis of head neck cancer.

Our response: Thank you for this comment. As the reviewer pointed out, salivary gland biopsy should be considered as a histopathological examination with both advantages and disadvantages. In our case, submandibular lesion showed rapid growth and imaging examination including contrast-enhanced CT and ultrasonography revealed the fused lymph nodes at multiple sites, which represented some findings similar to those of metastatic lymph nodes as described in the text. Although fine needle aspiration biopsy is believed to be useful diagnostic tool for salivary gland lesions, insufficient materials especially for the lesion of lymph nodes sometimes fails to obtain the proper diagnosis, which might influence on the decision for subsequent treatment plan. Therefore, we finally decided to conduct open biopsy in our case.

2. Why did perform radical neck dissection for this case, the authors could explain the necessity of this dissection.

Our response: Histopathological findings of biopsy specimen including immunohistochemical staining were consistent with those of salivary duct carcinoma. Tuberculous cervical lymphadenitis was not evident, and pathological diagnosis of metastatic SDC was suggested as described in the text. Taken together with the results of imaging examination, we obtained final diagnosis of salivary duct carcinoma with multiple metastatic cervical lymph nodes and decided to perform tumor resection combined with ipsilateral radical neck dissection.