Dear Editors and Reviewers,

We are very grateful to the editors and reviewers for your time and constructive comments on our manuscript. Your suggestions have enabled us to improve our work. Based on the instructions provided in your letter, we uploaded the file of the revised manuscript.

Appended to this letter is our point-by-point response to the comments raised by the reviewers. The comments are reproduced and our responses are given directly afterward in a different color (blue).

We would like also to thank you for allowing us to resubmit a revised copy of the manuscript.

We hope that the revised manuscript will be accepted for publication in the Journal of World Journal of Clinical Cases.

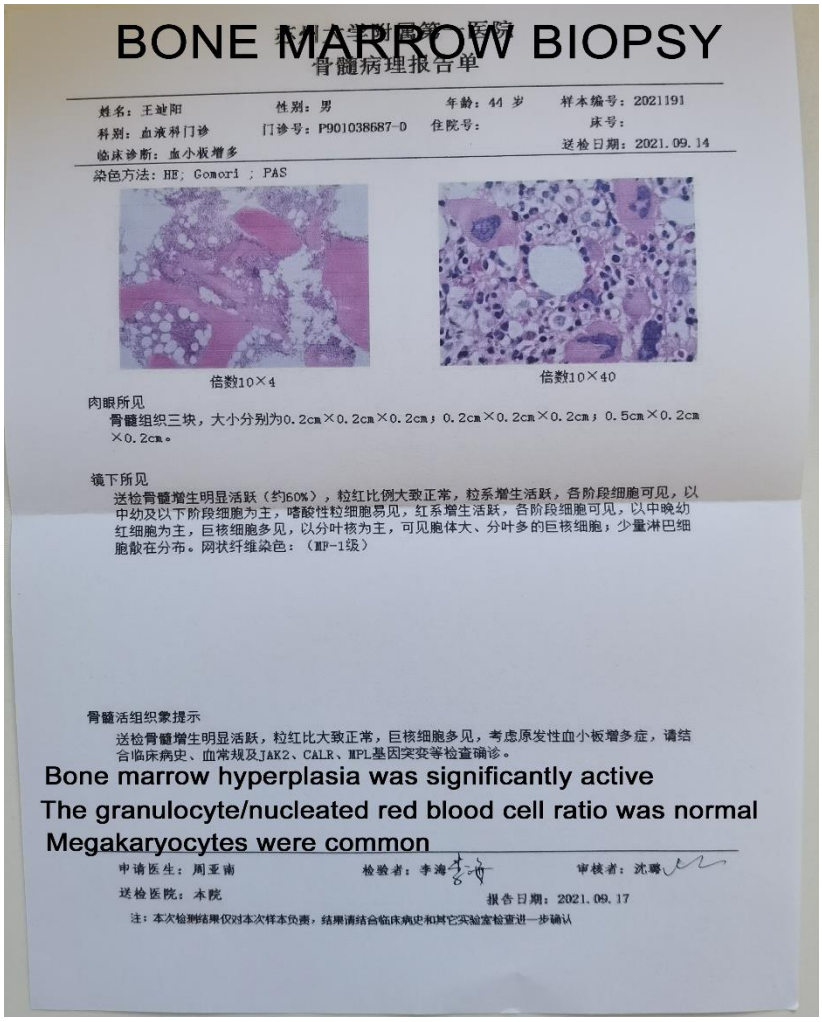
Sincerely,

EDITORIAL OFFICE'S COMMENTS

(1) Science editor:

First, please reconsider the accuracy of the diagnostic side in the manuscript and propose more favorable supporting information.

Response：We are grateful for your suggestions. Our previous diagnosis of ET was insufficient, especially the lack of bone marrow biopsy. During the recent telephone follow-up (November 12, 2021), we learned that the patient's platelet count increased again after stopped taking hydroxyurea, and then went to the outpatient department of Hematology. The hematologist raised questions the same as Reviewers and Editors about the ET diagnosis that we gave before. Fortunately, the hematologist completed the bone marrow biopsy, which showed that bone marrow hyperplasia was significantly active, the granulocyte/nucleated red blood cell ratio was normal, and megakaryocytes were common. Evidence of mutated JAK2 V617F and bone marrow biopsy substantiated the onset of ET.



BONE MARROW BIOPSY

骨髓病理报告单

姓名：王迪阳　性别：男　年龄：44 岁　样本编号：2021191
科别：血液科门诊　门诊号：P901038687-0　住院号：　床号：
临床诊断：血小板增多　送检日期：2021.09.14

染色方法：HE；Comori ；PAS

倍数10×4　倍数10×40

肉眼所见
骨髓组织三块，大小分别为0.2cm×0.2cm×0.2cm；0.2cm×0.2cm×0.2cm；0.5cm×0.2cm×0.2cm。

镜下所见
送检骨髓增生明显活跃（约60%），粒红比例大致正常，粒系增生活跃，各阶段细胞可见，以中幼及以下阶段细胞为主，嗜酸性粒细胞易见，红系增生活跃，各阶段细胞可见，以中晚幼红细胞为主，巨核细胞多见，以分叶核为主，可见胞体大、分叶多的巨核细胞；少量淋巴细胞散在分布。网状纤维染色：（MF-1级）

骨髓活组织象提示
送检骨髓增生明显活跃，粒红比大致正常，巨核细胞多见，考虑原发性血小板增多症，请结合临床病史、血常规及JAK2、CALR、MPL基因突变等检查确诊。

Bone marrow hyperplasia was significantly active
The granulocyte/nucleated red blood cell ratio was normal
Megakaryocytes were common

申请医生：周亚南　检验者：李海　审核者：沈曙
送检医院：本院　报告日期：2021.09.17
注：本次检测结果仅对本次样本负责，结果请结合临床病史和其它实验室检查进一步确认

Second, do not submit revision schema documents.

Response：We have resubmitted the new documents.

Third, please write the manuscript in the format required by this journal.

Response：This manuscript was changed in the format required by this journal.

(2) Company editor-in-chief:

I have reviewed the Peer-Review Report, the full text of the manuscript, and the relevant ethics documents, all of which have met the basic publishing requirements of the World Journal of Clinical Cases, and the manuscript is conditionally accepted. I have sent the manuscript to the author(s) for its revision according to the Peer-Review Report, Editorial Office's comments and the Criteria for Manuscript Revision by Authors. Before its final acceptance, the author(s) must provide the Signed Informed Consent Form(s)

or Document(s) of treatment. Please provide the original figure documents. Please prepare and arrange the figures using PowerPoint to ensure that all graphs or arrows or text portions can be reprocessed by the editor.

Response：We are very grateful for the suggestions and comments. According to the Editorial Office's comments and Peer-Review Report, we responded one by one and revised the manuscript accordingly. And we provided the Signed Informed Consent Form and the original figure documents in accordance with the requirements of you and this journal.

Reviewer #1：

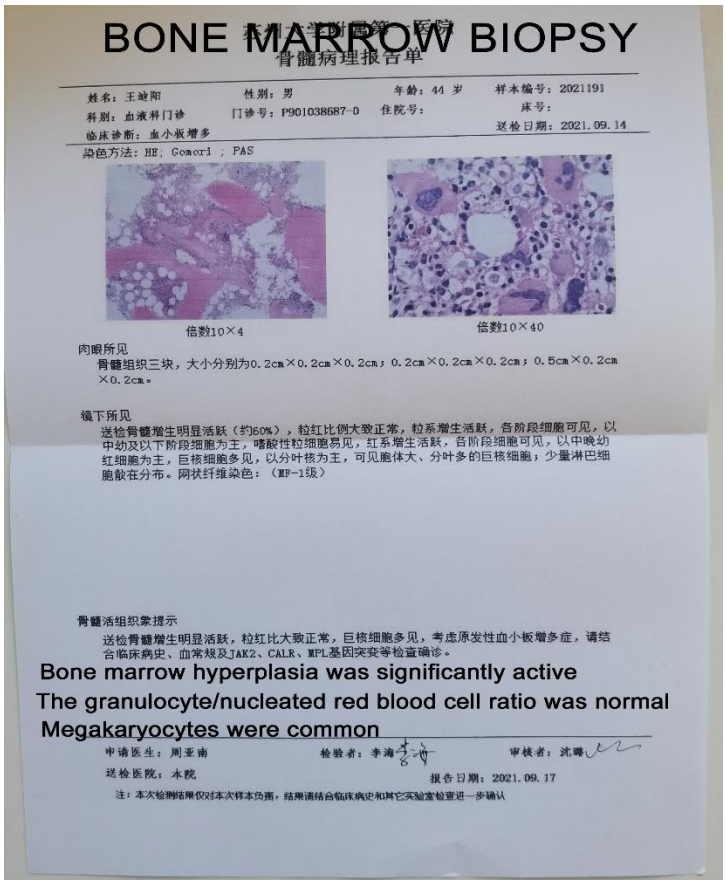
Scientific Quality: Grade C (Good)
Language Quality: Grade B (Minor language polishing)
Conclusion: Major revision

Specific Comments to Authors: The authors reported on the case of a 44 years old male who exhibited a myocardial infarction and was also diagnosed with essential thrombocythemia. The work describes in many details the infarction and the problems of its treatment. But what was less clear is the reason of the case report. What is understood is that the case is particular due to the extent and location of the coronary thrombus, on the one hand, and to the rarity of reports of myocardial infarction and thrombocythemia. However, authors should highlight the possibility of publication bias. It is well known that ET is often diagnosed in coincidence with a thrombotic event. So it is very likely that most of the myocardial infarctions associated with ET will not be reported. The cardiologists that read the paper are interested in the diagnostic and therapeutic challenges of the case. This is appropriately described. The haematologist is more interested in the differential diagnosis of the haematological disorders presenting with

thrombocytosis. In this aspect the paper has many limitations. First of all the diagnosis should be based on bone marrow histology. Bone marrow aspiration is not sufficient for the diagnosis. The WHO criteria need a specific morphology of megakaryocytes and this aspect is important for distinguishing ET from prefibrotic myelofibrosis. Moreover, in the description of the diagnostic tests the authors mention "a normal myelodysplastic syndrome (MDS) immunophenotype and the absence of 45 leukemia-related fusion gene transcripts. These are not necessary tests. Better (even not necessary) would be to analyze the presence of accessory myeloid mutations. In the discussion the authors report "fewer than 35 cases reports published in the literature" of AMI due to ET. This should be reported in more detail and case references should be listed. The paper needs editing improvements. Many acronyms are not clarified. Figure 3 è illegible.

Response：We thank the reviewer for the valuable comments. To be more clear and in accordance with the concerns of the reviewer, we have added a brief description as follows: In the clinical work of the Department of Cardiology, we pay more attention to the traditional cardiovascular risk factors of patients, and it is easy to ignore thrombocytosis or reduce these non-traditional cardiovascular risk factors. Past research found that both thrombocytopenia and thrombocytosis at hospital admission in post -Acute coronary syndrome (ACS) patients are associated with a significant almost two times higher 5-year mortality rate[1]. This was also one of the reasons why we further tested for the patient. Unfortunately, after we did a bone marrow morphological analysis, it suggested thrombocythemia, and myelodysplastic disease needs to be excluded, so we only carried out myelodysplastic syndrome (MDS) and 45 leukaemia-related fusion gene transcripts tests, and walked a detour in the diagnosis of the disease. During the recent telephone follow-up (November 12), we learned that the patient's platelet count increased again after stopped taking hydroxyurea, and then went to the outpatient department of Hematology. The hematologist raised questions the same as Reviewers and Editors about the ET diagnosis that we gave before. Fortunately, the hematologist completed the bone marrow biopsy, which showed that bone marrow hyperplasia was significantly active, the granulocyte/nucleated red blood cell ratio was normal, and megakaryocytes were common. Evidence of mutated JAK2 V617F and bone marrow biopsy substantiated the onset of ET. This also reminds us of our future work ideas. We should consult more specialists for professional advice to avoid making such mistakes again. There may be more AMI caused by ET that is ignored in clinical practice than reported in the literature, especially in patients with traditional cardiovascular risk factors. In our study, for the first time, we reported a case of an LM trifurcation lesion in NSTEMI caused by ET, including continuous stenosis lesions from the LM to the ostial LAD and an obvious thrombotic lesion in the ostial and proximal LCX. In addition to the extent and location of the coronary thrombus special, our purpose of writing this case report is also to emphasize the increase in platelets, especially ET

with thromboembolism as the first feature, which requires more attention and treatment of the primary disease, thereby reducing the recurrence of hromboembolic events.


BONE MARROW BIOPSY

骨髓病理报告单

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染色方法：HE; Gomori ; PAS

倍数10×4　倍数10×40

肉眼所见
骨髓组织三块，大小分别为0.2cm×0.2cm×0.2cm；0.2cm×0.2cm×0.2cm；0.5cm×0.2cm×0.2cm。

镜下所见
送检骨髓增生明显活跃（约60%），粒红比例大致正常，粒系增生活跃，各阶段细胞可见，以中幼及以下阶段细胞为主，嗜酸性粒细胞易见，红系增生活跃，各阶段细胞可见，以中晚幼红细胞为主，巨核细胞多见，以分叶核为主，可见胞体大、分叶多的巨核细胞；少量淋巴细胞散在分布。网状纤维染色：（MF-1级）

骨髓活组织象提示
送检骨髓增生明显活跃，粒红比大致正常，巨核细胞多见，考虑原发性血小板增多症，请结合临床病史、血常规及JAK2、CALR、MPL基因突变等检查确诊。

Bone marrow hyperplasia was significantly active
The granulocyte/nucleated red blood cell ratio was normal
Megakaryocytes were common

申请医生：周亚南　检验者：李海　审核者：沈晔
送检医院：本院　报告日期：2021.09.17
注：本次检测结果仅对本次样本负责，结果请结合临床病史和其它实验室检查进一步确认

In the discussion the authors report "fewer than 35 cases reports published in the literature" of AMI due to ET. This should be reported in more detail and case references should be listed.

Response：We are grateful for the suggestion. We searched the literature through Pubmed about the case report of AMI directly caused by ET fewer than 35.[2-35] We are also very happy to provide all of the cases reports of AMI due to ET for the article, but we have our own worries. Considering that if all case references of AMI due to ET are to be listed, the article may be cumbersome. We are reading these documents carefully, hoping to sort out their similarities and differences.

Many acronyms are not clarified.

Response：Regarding the suggestion about the acronyms, we modified them carefully.

Figure 3 è illegible.

Response：**Line 9, page9…**Thank you for the Figure 3 suggested. The precedent Figure 3 has been replaced and added the bone marrow biopsy results. (new Figure 3)

Reviewer #2：

Scientific Quality: Grade C (Good)
Language Quality: Grade B (Minor language polishing)
Conclusion: Major revision

Specific Comments to Authors: This is an interesting case report of NSTEMI in a patient with previously undiagnosed ET. The paper is well-written but needs several revisions before acceptance: 1. The manuscript has not been submitted using the suggested template of the journal. 2. The references need to be revised to match the style of the journal. 3. ET is a myeloproliferative neoplasm (MPN), the denomination of myeloproliferative syndrome is no longer used. Please correct throughout the paper. 4. It is important to mention that the WHO 2016 diagnostic criteria require the execution of a bone marrow biopsy to differentiate ET from prefibrotic primary myelofibrosis. 5. I think the immunophenotyping you performed (via flow-cytometry) was for the diagnosis of

acute (myeloid) leukemia and not for MDS. How did you perform the detection of gene fusions for acute leukemia screening? 6. I think the paper would also benefit from the input of a hematologist and laboratory medicine specialist, particularly the one who performed the genetic testing and flow-cytometry. The cardiologist's perspective is valuable but the readability of the case report and its scientific accuracy would be higher if we could also see the hematologist's perspective on the case. 7. In the future, more exact diagnostic and screening techniques for MPNs, particularly useful in the early detection of thrombosis, might be developed. I would suggest the authors to search in PubMed/Medline for papers regarding the use of liquid biopsy in myeloproliferative neoplasms.

We thank the reviewer for the valuable comments：

1. The manuscript has not been submitted using the suggested template of the journal.

Response：Thank the reviewer for underlining this deficiency. The text was modified according to the comment suggested by the reviewer.

2. The references need to be revised to match the style of the journal.

Response：Thank the reviewer for the suggestion about the style of reference. This section was modified according to the information suggested by the reviewer.

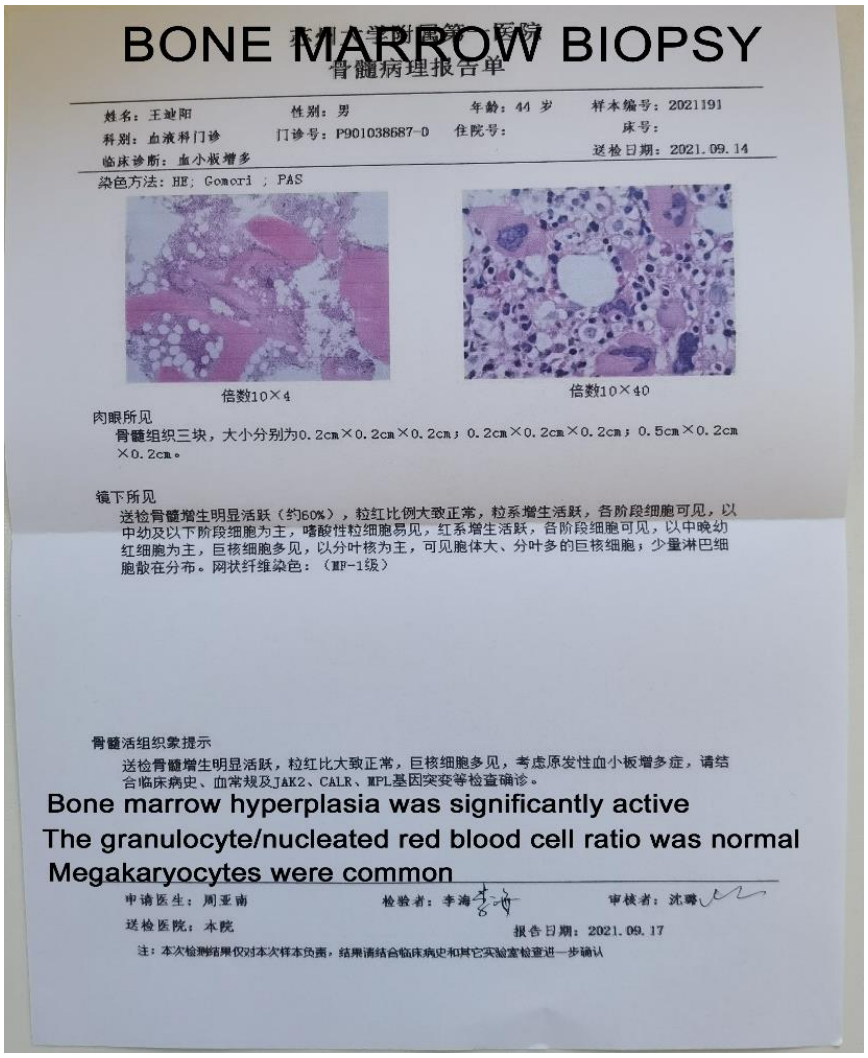
3. ET is a myeloproliferative neoplasm (MPN), the denomination of myeloproliferative syndrome is no longer used. Please correct throughout the paper.

Response：Thank you for underlining this deficiency. This section was revised and modified according to the information showed in the work suggested by the reviewer.

4. It is important to mention that the WHO 2016 diagnostic criteria require the execution of a bone marrow biopsy to differentiate ET from prefibrotic primary myelofibrosis.

Response：Our early diagnosis of patient with ET now seems to be insufficient. During the recent telephone follow-up (November 12, 2021), we learned that the patient's platelet count increased again after stopped taking hydroxyurea, and then went to the outpatient department of Hematology. The hematologist raised questions the same as Reviewers and Editors about the ET diagnosis that we gave before. Fortunately, the hematologist completed the bone marrow biopsy, which showed that bone marrow hyperplasia was significantly active, the granulocyte/nucleated red blood cell ratio was

normal, and megakaryocytes were common. Evidence of mutated JAK2 V617F and bone marrow biopsy substantiated the onset of ET.



BONE MARROW BIOPSY

骨髓病理报告单

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临床诊断：血小板增多　送检日期：2021.09.14

染色方法：HE；Gomori ；PAS

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肉眼所见
骨髓组织三块，大小分别为0.2cm×0.2cm×0.2cm；0.2cm×0.2cm×0.2cm；0.5cm×0.2cm×0.2cm。

镜下所见
送检骨髓增生明显活跃（约60%），粒红比例大致正常，粒系增生活跃，各阶段细胞可见，以中幼及以下阶段细胞为主，嗜酸性粒细胞易见，红系增生活跃，各阶段细胞可见，以中晚幼红细胞为主，巨核细胞多见，以分叶核为主，可见胞体大、分叶多的巨核细胞；少量淋巴细胞散在分布。网状纤维染色：（MF-1级）

骨髓活组织象提示
送检骨髓增生明显活跃，粒红比大致正常，巨核细胞多见，考虑原发性血小板增多症，请结合临床病史、血常规及JAK2、CALR、MPL基因突变等检查确诊。

Bone marrow hyperplasia was significantly active
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申请医生：周亚南　检验者：李海　审核者：沈晔
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5. I think the immunophenotyping you performed (via flow-cytometry) was for the diagnosis of acute (myeloid) leukemia and not for MDS. How did you perform the detection of gene fusions for acute leukemia screening?

Response： Thank you for pointing out the error in our article about immunophenotyping. When we wrote this case report, we mistaken MDS immunophenotyping (20 antibodies) for MDS. Just like you said, MDS immunophenotyping (via flow-cytometry) is for the diagnosis of acute (myeloid) leukemia and not for MDS. As a cardiovascular physician, I have learned a lot from you. We perform the detection of gene fusions by Real-time quantitative PCR.

6. I think the paper would also benefit from the input of a hematologist and laboratory medicine specialist, particularly the one who performed the genetic testing and

flow-cytometry. The cardiologist's perspective is valuable but the readability of the case report and its scientific accuracy would be higher if we could also see the hematologist's perspective on the case.

Response：Thank you for underlining this deficiency. As a cardiovascular physician, I always think that hematology is the most difficult subject in medicine, because it is not only abstract, but also difficult to understand. We are not good at diagnosis and treatment of blood system diseases. This is why I have always admired the doctors in the department of hematology very much. I was informed of the importance of bone marrow biopsy to ET through consulting with a hematologist. I also learned that the thrombotic events of ET are far greater than bleeding events. At the same time, AMI caused by ET is indeed very rare. Once there is a perspective suitable for this case, we will actively share it. Hope to get your help and advice.

7. In the future, more exact diagnostic and screening techniques for MPNs, particularly useful in the early detection of thrombosis, might be developed. I would suggest the authors to search in PubMed/Medline for papers regarding the use of liquid biopsy in myeloproliferative neoplasms.

Response：Thank you for the suggestion for us to search for the use of liquid biopsy in myeloproliferative neoplasms. After searching the literature, we found the liquid biopsy and liquid biopsy-based biomarkers (cell-free DNA, extracellular vesicles, microparticles, circulating endothelial cells) could be used in MPNs for diagnostic and prognostic purposes. Future research is needed to clarify whether this technique can be employed to differentiate between MPN subtypes and secondary causes of erythrocytosis, thrombocytosis and myelofibrosis, as well as to predict the development of thrombosis. The liquid biopsy will bring more timely diagnosis and treatment, and patient compliance will also be higher.

Reviewer #3:

Scientific Quality: Grade C (Good)
Language Quality: Grade B (Minor language polishing)
Conclusion: Minor revision
Specific Comments to Authors: 1 Title. Does the title reflect the main subject/hypothesis of the manuscript? Yes 2 Abstract. Does the abstract summarize and reflect the work described in the manuscript? Yes 3 Key words. Do the key words reflect the focus of the manuscript? Yes 4 Background. Does the manuscript adequately describe the background, present status and significance of the study? Yes 5 Methods. Does the manuscript describe methods (e.g., experiments, data analysis, surveys, and clinical trials,

etc.) in adequate detail?Yes 6 Results. Are the research objectives achieved by the experiments used in this study? What are the contributions that the study has made for research progress in this field? Yes 7 Discussion. Does the manuscript interpret the findings adequately and appropriately, highlighting the key points concisely, clearly and logically? Are the findings and their applicability/relevance to the literature stated in a clear and definite manner? Is the discussion accurate and does it discuss the paper's scientific significance and/or relevance to clinical practice sufficiently? Yes 8 Illustrations and tables. Are the figures, diagrams and tables sufficient, good quality and appropriately illustrative of the paper contents? Do figures require labeling with arrows, asterisks etc., better legends? Yes 9 Biostatistics. Does the manuscript meet the requirements of biostatistics? Yes 10 Units. Does the manuscript meet the requirements of use of SI units? Yes 11 References. Does the manuscript cite appropriately the latest, important and authoritative references in the introduction and discussion sections? Does the author self-cite, omit, incorrectly cite and/or over-cite references? Yes 12 Quality of manuscript organization and presentation. Is the manuscript well, concisely and coherently organized and presented? Is the style, language and grammar accurate and appropriate? Fair 13 Research methods and reporting. Authors should have prepared their manuscripts according to manuscript type and the appropriate categories, as follows: (1) CARE Checklist (2013) - Case report; (2) CONSORT 2010 Statement - Clinical Trials study, Prospective study, Randomized Controlled trial, Randomized Clinical trial; (3) PRISMA 2009 Checklist - Evidence-Based Medicine, Systematic review, Meta-Analysis; (4) STROBE Statement - Case Control study, Observational study, Retrospective Cohort study; and (5) The ARRIVE Guidelines - Basic study. Did the author prepare the manuscript according to the appropriate research methods and reporting? Yes 14 Ethics statements. For all manuscripts involving human studies and/or animal experiments, author(s) must submit the related formal ethics documents that were reviewed and approved by their local ethical review committee. Did the manuscript meet the requirements of ethics? Yes There are several technical glitches. 1. Grammatical corrections suggested in the proof returned herewith. 2. Some references missing in text. 3. Bibliography differently detailed. Not uniformly Vancouver style. 4. In citing references in text, the period or comma should come before the brackets of reference number not after.

Response：We are grateful for all the above suggestions and comments. These suggestions and comments were revised and modified in the new text.

Line 14, page1…We have modified this expression in the full form of LM in the sentence according to the comment.

Line 32, page1…We have modified this expression of PLT in the sentence according to the comment.

Line 35, page1…We have modified this expression in the full form of FKBT in the sentence according to the comment.

Line 24, page2…We have modified this expression in the full form of ET in the sentence according to the comment.

Line 26, page2…We have modified this expression of PLT in the sentence according to the comment.

Line 27, page2…We have modified this expression of singular and plural in the sentence according to the comment.

Line 19-22, page3…This sentence was rephrased according to the comment.

Line 34-35, page3…We have modified this expression in the full form of NSTEMI in the sentence according to the comment.

Line 36, page4…We have modified this expression in the full form of PCI in the sentence according to the comment.

Line 37, page4…This sentence was rephrased according to the comment.

Line 37-38, page4…This sentence was rephrased according to the comment.

Where are ref 1 and 2 quoted? I did not see references 2, 8!!!!

Response：Ref 1 is in Line 2, page2. Ref 2 is in Line 21, page2. Ref 8 is in Line 23, page4.

Please ensure that all of the text has been translated to English. Please note that we have not checked the text in your images because they are not editable in Word. If you would like them to be edited, please contact our support staff.

Response：**Line 9, page9…**Thank you for the Figure 3 suggested. The precedent Figure 3 has been replaced and added the bone marrow biopsy results. (new Figure 3)

While quoting references, the period or comma should come before the bracket of the reference number uniformly throughout the paper.

Response：Thank you for underlining this deficiency. We have modified the period or comma before the bracket of the reference number uniformly throughout the paper.

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