Revision list

Reviewer 1	Reply
The case report is quite interesting. The content of the manuscript is well described and clear, nevertheles some points must be taken into consideration.	
1.-It would be helpful discussing the finding of IgE >5000 wich could also lead to suspecting of other syndromes. Since the IgE levels were of >5000 and treatmet goal was reducing 35% of its concentration. Also especific IgE was only of 66.4 ku/L, manuscript is not clear mentioning if it is sIgE.	Thank you for the insightful comments. In the revised manuscript, we have discussed the diseases associated with IgE>5000 (line 176-line 193), including ABPA, hyperimmunoglobulin E syndrome, and IgE myeloma. What you said is right, the sIgE level was only 66.4 ku/L.
2. - Finally, it is not clear at what point of the diagnostic / treatment the AGPA could be missdiagnosed. Including this to case presentation/discussion would be helpful for the readers.	Thank you for your question. The full forms of EGPA and CT have been included. The clinical manifestations of ABPA are non-specific, especially in the early stage of the disease, which can lead to misdiagnosis or missed diagnosis for many years. However, asthma is the most common clinical presentation. Therefore, in asthma management, regardless of the disease severity or the control status, the possibility of ABPA should be considered. It is suggested that skin test of aspergillus allergen and/or detection of aspergillus sIgE should be carried out in all asthmatic patients to determine the sensitization to aspergillus. For patients sensitized by aspergillus, further examination should be carried out to determine whether there is ABPA in a timely manner. Patients who have been sensitized by aspergillus but have not yet reached the ABPA diagnostic criteria should be followed up regularly to obtain timely diagnosis before bronchiectasis or obvious impairment of pulmonary function occurs. Patients with clinical suspicion of ABPA but who lack the above examination conditions, should be promptly transferred to a qualified hospital for diagnosis and treatment.
Reviewer 2	
Dear Author Thank you for the opportunity to review the manuscript titled " Allergic bronchopulmonary aspergillosis almost misdiagnosed as eosinophilic pneumonia - a case report". This was a very typical presentation of a case of ABPA and I had the pleasure of reading and reviewing it. Comments / Suggestions:	
1. Abstract could have been written in a better way to reflect the case. Abstract did present a typical case of ABPA. I am not sure if the authors	Thank you for the comment. We have rewritten several sentences in the abstract for better clarity. We have added the sentence: “This

wanted to highlight something special about the case, if that is so the abstract need to re-written.	patient was excluded from eosinophil related diseases through pathological biopsy, and showed typical pathological manifestations of ABPA"
2. A case report is not complete without a review of literature showing the number of cases reported earlier to show if it is a very rare presentation. I think several and too many cases of ABPA have been reported in the literature. If the authors wanted to discuss a case with atypical presentation or diagnostic challenges faced during its encounter, it need to be highlighted in the abstract and discussed well under " Discussion".	Thank you for the insightful comment. We completely agree with you. There are several published case reports of ABPA. However, there is a paucity of cases in which histopathological findings of lung biopsy are presented, which can present the typical pathological manifestations of ABPA to readers. We had added these sentences in the discussion section.
3. Abstract starts with " Allergic bronchopulmonary angiogenesis " and I think the authors meant " Aspergillosis".	Thank you for pointing this out. We have revised the expression to aspergillosis.
4. The authors have not discussed, why this was almost a missed diagnosis of pulmonary eosinophilia, when the presentation and laboratory work up is very classic of ABPA. Its unusual to consider idiopathic pulmonary eosinophilia in patient with a history of Asthma, presenting with 15 years history of intermittent symptoms, without fever and focal pulmonary infiltrate than a more diffused opacities found in eosinophilic pneumonia. The authors have done a wonderful job taking a detailed history that also suggested no exposure of the patient to endemic parasite areas.	In this article, we only made a differential diagnosis of eosinophilia and did not misdiagnose as eosinophilic pneumonia. To avoid misunderstanding, we have revised the title to "Allergic Bronchopulmonary Aspergillosis: A case report".
5. As per the criteria proposed by the International Society of Human and Animal Mycology working group for ABPA, this case easily meets the criteria for ABPA. Was a Immediate prick skin test followed by intradermal reactivity to Aspergillus performed? Because a negative for both can exclude ABPA from consideration and obligates further investigation to look for eosinophilic pulmonary syndromes.	Thank you for the insightful comment. The main reason for not doing Immediate prick skin test followed by intradermal reactivity to Aspergillus was the lack of availability of these tests at our hospital.
5. About writing: The article demonstrates a very passive tendency in writing style, poor sentence phrasing and too many grammar errors and I feel will need a major revision.	The revised manuscript has been extensively edited and proofread to eliminate all language-related issues.