Reviewer #1:

Specific Comments to Authors:

1. What was the biopsy result after the ultrasound guided core biopsy? (before guidewire localization)?
   The histopathology report corresponds to 1.5mm of high–nuclear grade ductal carcinoma in situ (DCIS) with comedonecrosis and microcalcifications associated within a fibroephitelial lesion that corresponds to a fibroadenoma. Hematoxylin and eosin stain slides revealed pleomorphic neoplastic cells within a fibrodenoma.

2. It would be good to add in the discussion, what are the challenges in the case and your recommendation? Nonpalpable breast mass – how do you plan to resect them.
   After the diagnosis of DCIS was reported by pathologist, to assurance a successful surgery for nonpalpable nodule, wire localization is needed.

3. When should clinically (on imaging) fibroadenomas be biopsied or resected? Guidelines? – size, characteristics, clinical suspicion?
   In adult patients, the American Society of Breast Surgeons recommends against routinely excising biopsy-proven FA that are <2 cm. The American College of Radiology Appropriateness Criteria for palpable breast masses even states that short term imaging follow-up (such as every 6 months for 2 years) is a reasonable alternative to biopsy for solid masses with probably benign features suggesting FA.[19]
   A core biopsy should be performed on a nodule that presents rapid growth. The criteria for rapid growth are: (1) volume growth rate ≥16% per month for patients younger than 50 years, (2) volume growth ≥13% per month for patients ≥50 years, and (3) mean change in dimension over a 6-month interval of >20, especially in patients over 40 years of age to exclude the possibility of phyllodes tumor or malignancy. [19]
   The indications for excision include size >30mm, considering that pre-operative biopsy is also insufficient to distinguish phyllodes tumor from fibroadenoma, and there is the possibility of underestimation. Other indications for surgical removal are for growing FA, a nodule with increased BI-RADS classification grade during the follow-up and core needle biopsy suggesting atypical hyperplasia or unusual pathologic features. Persistent discomfort and pain from a fibroadenoma are a relative indication to consider surgical excision. Another indication for surgical removal is patient´s request or cosmetic concerns. [6,15,16,17,18]

4. In case of a CNB of a fibroadenoma, but imaging has calcifications- should outright resection be performed? Or are there preoperative test(s) that should be performed?

The microcalcifications within the nodule was suspicious (BI-RADS 5). If the histopathologic report was no concordance with the imaging, the surgical was indicated to corroborate the diagnosis.

5. A core biopsy should be performed on a fibroadenoma that presents more than 20% growth in 6 months, especially in patients over 40 years of age, to exclude the possibility of malignancy. – “on a fibroadenoma” mean you already have a tissue diagnosis beforehand or clinical suspicion still of a fibroadenoma? Or you mean “should be performed”on breast lesions with specific clinical characteristics? There are no clinical findings in a non-palpable mass.

6. For the differential diagnosis, is this for breast nodules with calcifications? Or breast nodules considered as pure fibroadenoma? The DDx you mentioned did not mention similar findings in your case where a presence of a breast nodule with calficifcations. Figure 3 you mentioned microcalcifications but in the DISCUSSION, you mentioned “In our case, the macrocalcifications were the key for the diagnosis of DCIS within fibroadenoma”
   We re-write the manuscript and the differential diagnoses to consider for a nodule with suspicious microcalcifications are fat necrosis, initial degenerating fibroadenoma, phyllodes tumor, triple-negative, mucinous, papillary, and metaplastic carcinoma. We explain the characteristics of microcalcifications of each tumor and fat necrosis.

7. DCIS in general – what is the guideline? Breast option for total or conservative mastectomy? Axillary – When Staging may be applied?
   The treatment of choice is conservative surgery, if 2 or fewer suspicious lymph nodes are found on imaging, or 2 or fewer positive lymph nodes are confirmed by needle biopsy, then is recommended sentinel lymph node mapping. Adjuvant therapy includes radiotherapy and endocrine therapy.

8. Key message in my own opinion, nonpalpable breast nodules (suspected of fibroadenoma (since you did not mention CNB result) with microcalfications (such as in your case) -a DCIS can be considered. Since the lesion is nonpalpable, wire localization + excision is warranted.
   Thanks for your comment I add it on the manuscript.

9. In your conclusion - The radiologist should consider this differential diagnosis when a nodule with atypical imaging findings or an increase in size of 20% or more occurs during follow-up studies. A core biopsy should be performed to confirm or exclude the diagnosis. – but no mention of the calcifications.
   I rewrite the manuscript to add that part.