Dear Dr. Jin-Xin Kong,

It is with great pleasure that we submit our revised case report to the World Journal of Gastrointestinal Oncology, entitled "A Rare Case of Primary Esophageal Diffuse Large B Cell Lymphoma Presenting with Tracheoesophageal Fistula and Review".
We have read over the comments of all three reviewers and made appropriate changes to our manuscript.

Here are our responses:
Reviewer 1: An interesting and important clinical observation, useful for physicians of many specialties. I allowed myself to make some minor corrections (they are highlighted in the text of the article). I hope they will be useful.
Response:
Thank you for your review and comments. I have made the corrections as you suggested, I hope you will find it more complete

Reviewer 2: This is a case report of primary esophageal Diffuse Large B Cell Lymphoma with trachea-eosophagal fistula. The manuscript is well written and illustrations are informative. Major comments: The most important concern is the clinical report by itself: What is the normal LDH value? Which is the distance between dental arch and eosophagal tumor? Which is the result of standard NHL work-up: complete biology, immunoglobulins, β2-microglobulin, viral serology, bone marrow biopsy, cerebrospinal fluid cytology and biology, etc.? The other important concern is the description of treatment and patient outcome. The discussion and references are informative Minor comments: no abbreviation should be used in the abstract; they should be defined in the body of the manuscript. It is not necessary to give the definition of NHL.
Response:
Thank you for you review and comments. I have made the corrections as you suggested. 1. Added normal LDH value, 2. There was no distance between dental arch and tumor documented in EGD or bronchoscopy reports. 3. I added some NHL work-up included: HIV screening, more immunohistochemical stains but β2 microglobulin, CSF study and bone marrow biopsy were not done. 4. I added patient outcome to the revised version since when we first wrote this case, patient was just received 2 cycles of treatment. I hope this will help this report to be more useful.

Reviewer 3: This case report is very interesting and rare. It is helpful to know if the patient has been immunologically investigated. Has he immune deficits? For the differential diagnosis of DLBCL with a possible Hodgkin's lymphoma, it would have been good to perform an immunohistochemical stain for CD15 (even if Hodgkin or Reed Sternberg cells were not seen, as I suspect). It is regrettable that the authors did not provide information on the further patient evolution under treatment. How was it fed and how evaluated the weight curve? He remains with

an immune deficiency throughout the treatment and another 6 months after the completion of rituximab therapy. Have been taken some preventive measures in this regard? I believe the article deserves to be published because it is useful for clinicians.

Response:

Thank you for your review and comments. I have corrected/added more data as you suggested, 1. HIV screening was done and negative, 2. I added more immunohistochemical stains, 3. Patient outcome was added in the revised version since when we first wrote this case, patient was just received 2 cycles of treatment. I hope this will help this report to be more useful.

Thank you so much for your consideration.

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