

Dear editors and reviewers:

I am very grateful to your comments for the manuscript. According with your advice, we amended the relevant part in manuscript. The following is a point-by-point response to the reviewer comments.

Response to reviewer #1:

1.Major comments 1: As mentioned in general comment, authors need to clarify the presence or absence of complications of other thyroid diseases, including Graves' disease, which is considered to be the most common cause of thyroid storms. How about an ultrasound findings? Please describe TSH receptor antibody, especially TSH receptor stimulating antibody. Please clarify whether the thyroid storm was caused by levothyroxine alone or with other thyroid complications.

Response: We are extremely grateful to reviewer for pointing out this problem. In reality, anti-thyroid antibodies were examined on admission and the results has been added to the text (Line/Page: 20-22/4) and table1. Thyroglobulin antibody (TGAb) level was 583.4 IU/mL, thyroid peroxidase antibody (TPOAb) level was 30.8 IU/mL, and thyrotropin receptor antibody (TRAb) level was <0.3 IU/L, so Graves' disease was not considered. The patient had no history of upper respiratory tract infection and neck pain before onset, and there was no thyroid tenderness after admission (it has been added to the text (Line/Page:15/4)) , so subacute thyroiditis could be excluded. Thus we believe that the thyroid storm was caused by levothyroxine alone. Regretful, the patient did not have a thyroid ultrasound.

2.Major comments 2: As authors know, thyroid storms are triggered by some stimulus factor. Did this patient have any stress, including infections?

Response: The patient developed thyroid storm without obvious inducement. The reason was considered to be the intake of large amounts of levothyroxine, and levothyroxine has a long half-life.

3.Major comments 3: Why authors treated tachycardia by propranolol, beta 1 non-selective blocker.

Response: In addition to treating tachycardia, propranolol also reduces the conversion of FT4 to FT3 in peripheral blood, so we chose propranolol as the first choice.

4.Major comments 4: The authors should describe in more detail why she was diagnosed with hypothyroidism. And how about thyroid function test when she was diagnosed with depression?

Response: The patient was diagnosed with hypothyroidism due to fatigue 3 years ago and was treated with levothyroxine (the reason why she was diagnosed with

hypothyroidism has been added to the text (Line/Page:2-3/4)). However, her parents were unable to provide the results of her thyroid function, anti-thyroid antibodies and thyroid ultrasound at the time of diagnosis of hypothyroidism. During the replacement treatment with levothyroxine, she did not monitor thyroid function, so her thyroid function was unknown when she was diagnosed with depression.

5.Minor comments 1: Author need to describe the dose of levothyroxine in abstract.

Response: The dose of levothyroxine has been added in abstract (Line/Page:15/2) .

6.Minor comments 2: At physical examination, authors need to describe heart rate was regular or not.

Response: In the physical examination section of the manuscript, the patient's heart rate was described as 103 beats / min.

Response to reviewer #2:

1.Comment 1: Could it be possible that patient was manifesting symptoms of benzodiazepine withdrawal since the levothyroxine overdose occurred concomitantly with overdose of clonazepam and zolpidem. Was benzodiazepine withdrawal managed adequately in this patient ? How was that managed ?

Response: We deeply appreciate the reviewer's suggestion. Withdrawal symptoms mainly occur in patients who take benzodiazepines continuously for a long time and stop abruptly. Mild symptoms mainly manifested as excitement, insomnia, anxiety, tension, irritability, palpitation, dizziness, muscle tension, spasms, pain, etc. Severe withdrawal symptoms include grand mal seizures and even hallucinations. The patient did not take the drug continuously, and her symptoms were not consistent with the withdrawal symptoms of benzodiazepine drugs. So we considered that she did not develop benzodiazepine withdrawal symptoms. Regrettably, we didn't consult a psychiatrist. When the patient was discharged, we enjoined her parents to take her to a psychiatric clinic for a consult.

2.Comment 2: Authors used interesting phrase of 'mental stimulation' that possibly led to the overdose. This phrase sounds primitive and non-clinical. Can it be replaced/clarified? Do the authors mean stress/worsening depression?

Response: At that time, the patient's parents had a heated argument, so she took a lot of drugs to kill herself. That's the reason why we used phrase of 'mental stimulation' .

3.Comment 3: Was psychiatry service consulted/involved in this patient's management in the light of history of depression and the near-fatal overdose?

Response: We are grateful for the suggestion. During hospitalization, the patient presented mainly with symptoms of levothyroxine overdose, so we mainly dealt with thyrotoxicosis and thyroid crisis. When she was discharged, we repeatedly advised her parents to take her to a psychiatric clinic for consultation.