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April 11, 2022

**Andrzej S Tarnawski**

Editor-in-Chief

**World Journal of Clinical Cases**

April 11, 2022

Please find enclosed the edited manuscript in Word format (file name: **Manuscript NO: 75605**).

**NO. 75605**

**Phosphoglyceride crystal deposition disease requiring differential diagnosis from malignant tumors and confirmed by Raman spectroscopy: a case report**

**Yu OHKURA, Hironori URUGA, Masato Shiiba, Shinji ITO, Hayato SHIMOYAMA, Makiko Ishihara, Masaki UENO, Harushi UDAGAWA**

Dear Editor and Reviewers,

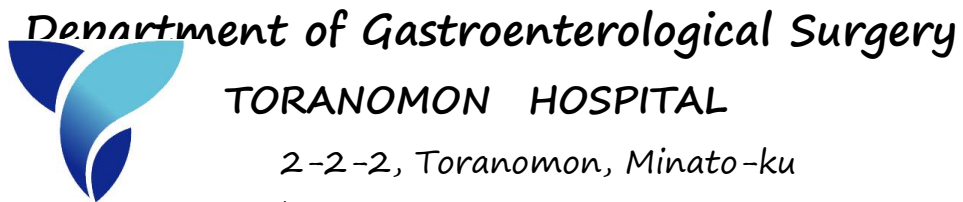
Thank you very much for your letter dated Feb 9, 2022. We found the reviewers' kind and detailed suggestions most helpful and have revised the manuscript accordingly. Please find the revised manuscript, including changes indicated by underlining, and pages with our point-by-point responses to the reviewers' comments and our corresponding changes. We submit this revised manuscript for your consideration for publication in **World Journal of Clinical Cases**.

We appreciate the reviewers' comments and their understanding of our study. We hope we could discuss with you about Phosphoglyceride crystal deposition disease requiring differential diagnosis from malignant tumors and confirmed by Raman spectroscopy. Again, thank you for your meaningful suggestions.

We look forward to hearing from you again at your earliest convenience.

Sincerely yours,

**Yu Ohkura, MD, PhD**



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**Reviewer: 1**

**Peer-review report Reviewer #1:** This paper reported a method that has not been previously reported for the diagnosis of PCDD. It's interesting and meaning.

Thank you for your high evaluation of my manuscript.

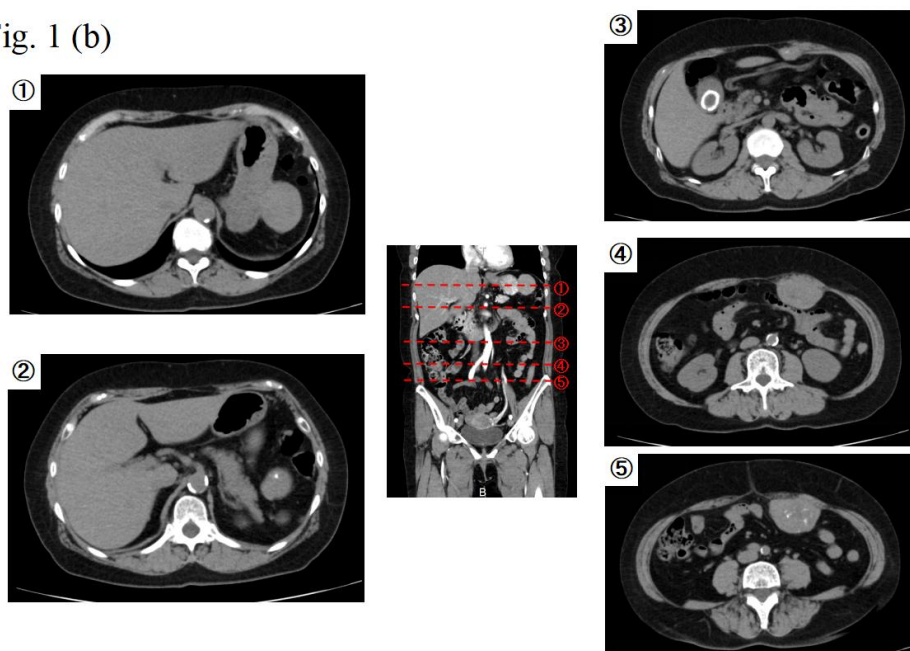
**Reviewer #2:** This is an impressive article about phosphoglyceride crystal deposition disease. Granuloma in the abdomen accompanied by intensive FDG uptake can easily lead to a diagnosis of sarcoma. A few suggestions/ questions I have for them are:

Thank you for reviewing my manuscript. The answers to your questions are listed below.

1. Figure 1 shows calcification density in lesions 2, 3, and 5. Please provide non-contrast-enhanced CT images at the same level.

Thank you for the appropriate suggestion.  
I added the plain CT as Figure 1(b).

Fig. 1 (b)





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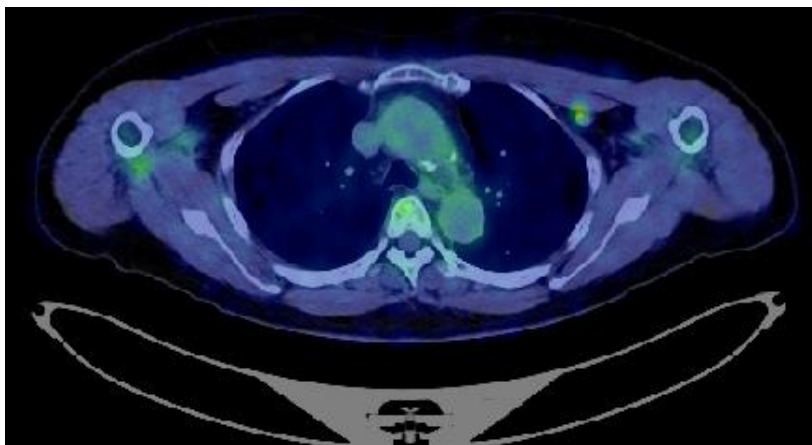
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2. Is the focal FDG uptake in the left axillary region on MIP (Figure 2) a lymph node?  
There seems to be no explanation for it.

Thank you for the appropriate suggestion. We apologize to editors for my lack of clarity. We sincerely agree with these editor's comments.

We added the following sentences in Case presentation section (see Page 4, Line 6).

And the left axillary lymph node also had high FDG uptake (SUV max: 3.51) and suspected lymph node metastasis.





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**3. The MIP (Figure 2) shows that parts 3 and 4 of the abdominal lesion overlap with the left renal collecting system. The lesion would be more clearly demonstrated by adding a mild right anterior oblique or mildly rotated MIP image.**

Thank you for the good suggestion.  
I added the rotated MIP image in Figure 2.



**4. Increase the color bar of the fusion image and indicate the range of SUV.**

Thank you for the appropriate suggestion. We sincerely agree with these reviewer's comments.

I added the color bar of the fusion image and indicate the range of SUV.