Reviewer's comment

Reviewer 1

The author presented an extremely rare and interesting case with details. However, the author should provide the chest x ray or chest CT before and after chemotherapy. It not only showed the therapeutic response, but also confirmed the diagnosis again.

- ⇨ Unfortunately, it was diagnosed at our hospital, but the treatment was performed at another hospital. However, I think it is meaningful to make differential diagnosis through pathologic confirmation of very rare case.

Reviewer 2

Title Page:

The title is referring to the "mimicking" of lymphoma, but in the text the differentiation of multiple myeloma from a lymphoma is not further described. This should be corrected or the title changed.

- ⇨ We revised the title.

Abstract:

In line 42 the abbreviation SS for Sjögren's Syndrome is used, although this abbreviation is only introduced in line 67.

- ⇨ We inserted SS in line 41.

The Background should give an idea of why this case report might be important and interesting to read, for example, the fact that rare diseases might coexist in one patient, causing contradictory test results and inconsistent clinical findings. The conclusion should also refer to this.

- ⇨ We revised your comments.

Core Tip:

the Sentence in lines 67-69 is repeated in the introduction, the discussion and the conclusion (where it does not belong, as it does not add to the aim of the article). The repeated usages should be rephrased to increase readability.

- ⇨ We corrected the sentences.

Introduction:

The sentence in lines 80-83 is not understandable, either it is incomplete or it should be rephrased to make its meaning clearer. It is repeatedly stated, that incidences of the diseases described are low. If numbers are available, they should be stated to illustrate the rarity.

- ⇨ We corrected the sentence that you pointed out

The end of the Introduction should again refer to the "question" raised by the case report (and it should be answered in the conclusion).

- ⇨ We removed the last sentence from the introduction section.

Case Presentation:

The details given in the case presentation are scarce. The complaints of the patient are not mentioned.

What symptoms led to the diagnosis of a gastric plasmacytoma?

- ⇨ Again, gastric plasmacytoma was diagnosed incidentally.

What were his symptoms concerning the Sjögren's Syndrome?

- ⇨ He complained dry eyes and dry mouth, but his symptoms improved after treatment. However, he complained swelling of the parotid glands and lymph nodes enlargement. So, we revised the personal and family history section.

Was the medication for Sjögren's Syndrome given sequentially or synchronous?

- ⇨ After administration of MTX and hydroxychloroquine, prednisolone was added sequentially. So, we revised the personal and family history section.

Did it have an effect on the course of the disease? Because the extensive lymphocytic infiltrations suggest a progressive disease.

- ⇨ We agreed with your opinion.

Was the amyloid material (line 149-150 "amorpheous proteinaceous material") further examined?

- ⇨ Yes. Congo-red stain for amorphous proteinaceous material was performed. Immunohistochemistry for kappa and lambda was performed.

What were the relevant diagnostic considerations leading to the given diagnoses? Which criteria were relevant?

- ⇨ As you know, the golden standard method for diagnosing amyloidosis is to check apple green birefringence under a polarized microscope. Also, it is necessary to identify the protein precursor to determine its subtype. We only checked the kappa and lambda light chains. Through the tests mentioned above, we diagnosed our patient with pulmonary amyloidosis.

Line 153: What is a nested PCR?

- ⇨ Mycobacterium tuberculosis nested PCR of lung biopsied tissue was performed to rule out the pulmonary tuberculosis.

Discussion:

Sjögren's Syndrome goes along with B-cell activation which can result in polyconal lymphocytic infiltration, monoclonal gammopathy and light chain amyloidosis. In rare cases a reactive, secondary amyloidosis with amyloid A deposits may be observed. It can even progress to B-Cell-Hodgkin-Lymphoma. In this case a different synchronous hematologic malignoma was present – multiple myeloma – which may also cause lymphocytic infiltrations, in this case monoclonal, and amyloidal deposits consist of light chains. If both diseases occur at the same time in the same patients the findings and test results can be contradictory and misleading. This point should be made clearer in the Discussion and the relevant diagnostic decisions leading to the final diagnoses should be mentioned. In this case, it was the histopathological examinations, which were important.

- ⇨ You are right. Because Sjögren's Syndrome goes along with B-cell activation, monoclonal gammopathy, amyloidosis, HL, and NHL can all occur. So, in order to differentiate it, we performed not only the LN but also the lung. LN biopsy showed findings suitable for plasmacytoma (mature plasma cell (+), CD138(+), Kappa (+)), and lung biopsy showed

findings suitable for amyloidosis (amorphous proteinaceous material deposition, Congo-red stain (+)). However, in our patient's lung biopsy, immunohistochemistry of kappa and lambda was negative. This is considered to be the point of differentiation from pulmonary amyloidosis caused by MM. So, we revised discussion section.

Lines 176-177: "SS often involves lung diseases, such as…and pulmonary amyloidosis" This is wrong. It often involves interstitial lung disease, sometimes primary pulmonary lymphoma and pleuritic, but the point of this article is, that pulmonary amyloidosis is very rare. So, this contradiction should be avoided.

⇨ We revised your comment.

Lines 235 – 240: No tests are mentioned to examine the amyloid deposits further, so the theoretical of a pulmonary amyloidosis caused by Multiple Myeloma must be considered, as the authors do. The conclusion, that the latter is unlikely the cause and therefore it must be a case of pulmonary amyloidosis and multiple myeloma associated with SS, cannot be followed because that constellation is also very rare and unlikely, so the conclusion does not necessarily follow from the findings. It should be discussed, what could be done to clear this uncertainty (for example examine the amyloid deposit further).

⇨ In order to differentiate amyloidosis caused by MM from amyloidosis caused by other causes, it is necessary to identify the protein precursor that forms amyloid, but we have only performed tests for kappa and lambda. So, we revised discussion section.