Reviewer #1:

Scientific Quality: Grade C (Good)

Language Quality: Grade B (Minor language polishing)

Conclusion: Accept (General priority)

Specific Comments to Authors: - Do you recommend any additional imaging modality after ultrasonography and color Doppler study before surgical intervention for such cases? - At discussion: please add the number of reference after the name of authors (Kovach et al.).

Response:

Thank you for the professional and careful review of the manuscript.

First, we recommend that patients with similar cases should undergo other imaging examinations in addition to gray-scale ultrasound and Color Doppler flow imaging (CDFI) before surgery. This case involves a patient we diagnosed and treated five years ago. Due to insufficient experience and inefficient equipment at the time, we only performed gray-scale ultrasounds and CDFI on the patient, which were insufficient. In current practice, we recommend imaging examination for patients with similar cases, as follows: perform routine ultrasound inspections first, including 2D and CDFI; ultrasonic elastography can be performed simultaneously, including strain elastography and shear wave elastography. It may be difficult to distinguish between benign and malignant masses after the above-mentioned examinations. We strongly recommend that patients undergo contrast-enhanced ultrasound (CEUS). CEUS, as a pure blood pool phenomenon technology, especially due to the rapid development of high-frame-rate CEUS in recent years, can show the richness of the blood supply and the blood supply pattern of the tumor, which helps differentiate benign and malignant tumors. In addition, CEUS can further clarify the tumor boundary and show whether the surrounding normal tissues have been invaded. If there is an invasion, it can show the range of invasion, which helps determine the scope of surgical resection and ensure that the resection margin is negative. Patients with these conditions can undergo magnetic resonance imaging (MRI) to provide more reference information; however, we do not recommend mammography. Although it is sensitive to calcification, IMT calcification is not common, and radiation cannot be ignored.

Second, I have added the reference number after the authors' name (Kovach et al.). This is the tenth reference. In the previous manuscript, we marked [10] at the end of the sentence because of negligence.

Reviewer #2:

Scientific Quality: Grade C (Good)

Language Quality: Grade B (Minor language polishing)

Conclusion: Minor revision

Specific Comments to Authors: This is indeed an interesting CASE, and the author also discusses related literature on this topic. It is suggested that more diagnosis suggestions can be made for this kind of case in the future. After all, the routine examination of blood can not be diagnosed.

Response:

Thank you very much for your professional review and affirmation of the manuscript.

We believe that imaging examination is the most important detection method for diagnosing this type of tumor before surgical intervention. Although histopathology is the gold standard for diagnosis, ultrasound-guided biopsy is usually employed to obtain tumor tissue specimens before surgery. The tissue obtained by this method may not reflect the full picture of the tumor, and IMT may mimic other benign or malignant breast lesions in cytology. Therefore, the significance of preoperative needle biopsy to diagnose IMT is limited. As stated in the manuscript, the final diagnosis still requires postoperative histopathological examination.

This case involves a patient we diagnosed and treated five years ago. Due to insufficient experience and inefficient equipment at the time, we only performed gray-scale ultrasound and Color Doppler flow imaging (CDFI) on the patient, and these were insufficient. In current practice, we recommend that patients with similar cases undergo contrast-enhanced ultrasound (CEUS) before surgery. Because, when the conventional ultrasound image of IMT is relatively regular in shape and has clear boundaries, the sonographer usually classifies it as either breast imaging reporting and data system (BI-RADS) type 3 or 4a. However, the early invasion of the surrounding tissues can be observed through CEUS. After all, IMT is a borderline tumor, and the invasion of surrounding tissues is possible. Once invasions are observed, BI-RADS can be upgraded to remind the surgeon to treat the mass at the earliest. In addition, another important role of preoperative imaging examination is to clarify the true boundary of the tumor and the extent of invasion of surrounding tissues, which helps determine the scope of surgical resection and prompts the surgeon to consider whether to expand the resection. We believe that CEUS and magnetic resonance imaging (MRI) can provide the above information accurately.

Then, we consulted some literature and found that IMT does not have specific serum tumor markers.