

Dear the Editor of **World Journal of Clinical Cases**,

Thank you so much for the effort and patience in reviewing our manuscript (Manuscript NO: 54779) entitled "**Multifocal neuroendocrine cell hyperplasia accompanied by tumorlet formation, and pulmonary sclerosing pneumocytoma: a rare case report**". The authors are grateful for the invaluable comments and suggestions proposed by reviewer/editors to improve the quality of our manuscript. We highlighted all the altered items in **Red Color**. The point-to-point responses to the reviewer/editors' comments and suggestions are listed in the following pages.

Best regards,

Dr. Weiqun Ao (Name of corresponding author)

Editor Comments:

Reviewer #1: This paper reports a rare clinical case of bronchiectasis with comorbid multifocal NEC hyperplasia, tumorlet, and PSP. The patient was followed up after undergoing CT imaging and received surgical resection. The title is in accordance with the main subject/hypothesis of the manuscript, and the abstract and the key words reflect the main results of the article. The manuscript clearly explains methods in adequate detail. I suggest to accept the manuscript with no specific comments.

Response: Thank you for your careful review and kind comments. We would be very grateful if this revised manuscript could be considered for publication in the **World Journal of Clinical Cases**.

Reviewer #2: This case report describes unusual histologic findings in a resected lobe from a patient with bronchiectasis and haemoptysis. It is clearly presented and the novel features are outlined in the text, as is the clinical significance of the various pathological findings. It is limited by a failure to present the clinical consequence for patient pathways - when might resection be appropriate? What follow up could be done to avoid resection in this population, since this is pre-malignant and thus risks of resection may wish to be avoided - this could be added to the discussion.

Response: Thanks for your suggestions. In this case, the patient had symptoms of bloody sputum for more than 4 months and hemoptysis for 1 week. After anti-inflammation treatment, the symptoms have not been alleviated. The patient was then undergoing CT scan, which revealed multiple nodules in the middle lobe of the right lung with unclear boundary. After 4 months' CT follow-up, the progression of the lesions was detected, which could not exclude the possibility of malignant tumor. Therefore, thoracoscopy and pneumonectomy of the middle lobe of the right lung were performed. At present, antibiotics are effective treatments for most of the patients with bronchiectasis, who do not need surgical treatment. The surgical indications include: 1. Active drug treatment is still difficult to control symptoms; 2. Massive hemoptysis is life-threatening or ineffective by drug and interventional therapy. Given that bronchiectasis with tumorlet and PSP may not usually require treatment, accurate preoperative diagnosis and long-term follow-up is of great importance. We added this in the "Discussion" part of the revised manuscript and added a new reference-[19].

The title reflects the main subject of the manuscript, as does the abstract, though the quality of the English in the abstract was perhaps not as good as the rest of the manuscript.

Response: Thanks for reminding us. We examined the abstract carefully and corrected some grammatical errors to meet the requirements of the Journal.

The work up of the patient was generally well described, however I would like to know more about the volume of the haemoptysis to understand whether resection would have been warranted from the symptoms, and would also be interested to know if radiological embolisation

was considered as a treatment for large volume haemoptysis (if indeed volume of blood is what triggered surgery). Multiple nodules and atelectasis would not generally be considered a reason to resect in my country, and we would usually watch and wait instead, in case the nodules represented infection which might resolve. What radiological features were specific or more worrying with regard to malignancy? This would have been a better reason to resect in our pathways. The main contribution that the study has made for respiratory medicine is to delineate the spectrum of neuroendocrine cell changes that can occur in such patients, and describe their relevance for the clinical community. The discussion pulls relevant literature together, and in particular states the risk of progression to a malignant tumor. The figures of CT images and histology are clear and helpful. References, CARE statement and ethics are covered appropriately.

Response: Thank you very much for your constructive suggestions, which contribute a lot to improve the quality of our work. Due to the rarity of bronchiectasis with tumorlet and PSP, it can be easily misdiagnosed. Pulmonary CT images often reveal signs of bronchiectasis, pulmonary consolidation, and numerous lung nodules with diameter ≤ 5 mm. If nodule growth or lesion progression is detected in the follow-up visits, the medical team should be cautious about the possibility of the tumorlet developing into a carcinoid. However, clinical diagnosis still relies on postsurgical pathological analysis. Because NEC hyperplasia and DIPNECH are usually small in size, obtaining tissue specimens is also a challenge for pathologists. This was a retrospective study. The pity is that the patient's volume of the haemoptysis was not mentioned in the hospital records.