Reply to Reviewers

To reviewer 1 (ID number 05429162):

Thank you for your advice and patience! It is necessary for us to revise our case according to your suggestions, and we believe that your advice for our case can significantly improve the quality of our case!

Comment 1. *[CASE PRESENTATION- history of past illness] 1) In this section, it is important to describe that the patient had a hyperparathyroidism or pituitary adenoma, to exclude the possibility that the patient has a MEN-1 related disease*

Reply: We have added the corresponding description in the [CASE PRESENTATION-history of past illness] section, and marked the adding sentence with a yellow marker.

Comment 2. *[CASE PRESENTATION- imaging examinations] 1) Indeed, the CT imaging is important for making diagnosis of NETs, however, it cannot be exclude other hypervascular tumor, such as metastatic carcinoma, pancreatic cystadenoma. For making differential diagnosis, the Magnetic Resonance Imaging (MRI) is important. Please describe the imaging result of MRI.*

Reply: Indeed, supplementary MRI is very important for differential diagnosis even though later evidence confirmed that the patient was not metastatic carcinoma or pancreatic cystadenoma, but unfortunately this patient did not have a MRI examination. Therefore, we have added corresponding remedial content in the [DISCUSSION] section, and marked the adding sentences with a yellow marker.

Comment 3. *The term "neuroendocrine tumor (NET)" should be reconsidered, according to the latest WHO guidelines. If the author diagnosed the lesion as neuroendocrine neoplasm with the Ki-67 proliferative index up to 20%, the lesion should be described as pancreatic neuroendocrine tumor Grade 1/2 (panNET G1/2). On the other hand, if the author diagnosed the lesion as neuroendocrine neoplasm without any information about the Ki-67 proliferative index, the lesion should be described as pancreatic neuroendocrine neoplasms (panNEN)*

Reply: Exactly, we have revised the all the terms "neuroendocrine tumor(NET)" in the text, and described the lesion as pancreatic neuroendocrine neoplasms(panNEN). Moreover, the final pathological diagnosis did not support the diagnosis of NET.

Comment 4. *[CASE PRESENTATION- further diagnostic work-up] 1) The author should describe the FNA pathological findings with Ki-67 proliferative index and positive/negative staining for immunohistochemistry, such as chromogranin A, CD56 and synaptophysin. These findings are crucial for diagnosing as neuroendocrine tumor/carcinoma. They also should be described as in the figures.*

Reply: The FNA could not provide immunohistochemical diagnosis unfortunately, such as CgA, CD56 or Syn, because this method can only be used for cytologic diagnosis.

Comment 5. *[TREATMENT] 1) There is no official name of the disease of "NET with borderline-malignancy". It should be preciously described according to the WHO guideline, especially in the surgically resected specimen*

Reply: Yes, we also realize that the description here is inaccurate. Limited by the diagnostic ability of intraoperative frozen section, as an immediate pathological diagnosis method that needs to guide the operation in a short time, it could not be as accurate as a paraffin section, so the results of frozen section could not be used as the final diagnosis. Therefore, we described as "Intraoperative frozen section examination considered the

specimen tending to be a type of panNENs, malignancy could not be excluded", and marked the revising sentences with a yellow marker.

Comment 6. *[TREATMENT] 2) There is several risk stratification score has been reported in the previous literature. Please describe the risk score of this case*

Reply: We have searched relevant study and added this content in [FINAL DIAGNOSIS] section, and marked the adding contents with a yellow marker.

Comment 7. *[DUSCUSSION] 1) The authors described the 19 cases of pancreatic paraganglioma which were previously reported. Details of these cases in terms of their prognosis, treatment, imaging features and preoperative diagnosis should be described and making a summary table.*

Reply: We have added the summary table to the text.

Comment 8. *[DUSCUSSION] 2) In this section, the authors describe the clinical imaging features and clinical manifestation of the pancreatic paraganglioma, however, there is very few references to support the authors' story, although the disease is relatively rare.*

Reply: We added literature based on previous literatures reporting in [DISCUSSION] section with regard of the clinical manifestation and clinical imaging features.

To reviewer 2 (ID number 05776522):

Thank you for your appreciate and affirmation! On the basis of previous language polishing, we have further accomplished the language editing process again.

To reviewer 3 (ID number 02861019):

Thank you for your appreciate and affirmation!

To reviewer 4 (ID number 05458177):

Thank you for your advice and patience! Exactly, we are also trying to find radiographic differential diagnostic protocols, however, imaging examinations are indeed difficult in the differential diagnosis, because pancreatic paraganglioma as they share similar characteristics with other types of panNENs, therefore, definite diagnosis of pancreatic paraganglioma mainly depends on postoperative histopathological and immunohistochemical examinations. Even so, we also recommend MRI for distinguishing panNENs/pan-paragangliomas from other types of hypervascular tumors, such as metastatic carcinoma or pancreatic cystadenoma, and added the content into the [DISCUSSION] section. At the same time, we discussed the significance of tumor marker detection, preoperative puncture, histopathological examination and immunohistochemical examination in the diagnosis of paraganglioma.

RE-REVIEW REPORT OF REVISED MANUSCRIPT

Summary Jiang et al. reported a clinical case of paraganglioma harboring lymph node metastasis. The paper provides very interesting data but it still needs a considerable revision to be acceptable for the World Journal of Clinical Cases.

[TREATMENT] 1) There is confusion of the diagnosis with neuroendocrine tumor and paraganglioma. If the patient was diagnosed with paraganglioma preoperatively, the authors should describe the preoperative diagnosis as pancreatic neuroendocrine tumor G1(panNET G1).

Reply: The diagnosis of paraganglioma was based on the postoperative histological and immunohistochemical examination. We described the preoperative provisional diagnosis of pancreatic NEN (panNEN) in the PREOPERATIVE DIAGNOSIS section.

Also, if the authors diagnosed as paraganglioma in the pancreas from surgical specimens, the GAPP score should be described in the outcome and follow-up section, or move the final diagnosis section after the treatment section.

Reply: As the final diagnosis of paraganglioma was made from surgical specimens, we moved the FINAL DIAGNOSIS section after the TREATMENT section, and the GAPP score was described in the FINLA DIAGNOSIS section.

[DUSCUSSION]t 1) The authors added the imaging findings for making differential diagnosis of paraganglioma/neuroendocrine tumor. However, the typical imaging findings of these tumors should be described.

Reply: It is difficult to accurately diagnose pancreatic paraganglioma preoperatively, because those imaging features are not specific to pancreatic paragangliomas as they share similar imaging characteristics with other types of panNENs, so we didn't mentioned in the article the imaging findings for making differential diagnosis of paraganglioma/neuroendocrine tumor. We acknowledged in the DISCUSSION section that the final diagnosis of

paraganglioma based on postoperative histopathological and immunohistochemical examinations are more reliable