Dear reviewer,

We have revised the manuscript according to your suggestions, and the revised parts have been marked in red, which are detailed below:

Question one: (Abstract) In the METHODS, it is described that the study subjects were three cases. However, Case 3 is not described at all in the RESULTS and CONCLUSION. Something should be mentioned on Case 3.

Answer:

RESULTS All patients were positive for CD56 and negative for EBER. Two patients had bone marrow involvement. Chemotherapy is the main treatment for BPDCN, but case 1 showed bone marrow suppression and case 2 developed recurrence after chemotherapy. Case 1 survived for 7 months, case 2 for 17 months, and case 3 for 9 months.

CONCLUSION An accurate pathological diagnosis is a precondition for treatment, and the diagnosis of BPDCN should be based on a combination of clinical symptoms, pathological characteristics, immunophenotype, and other auxiliary examinations. It is necessary to clarify the clinicopathological features and biological behavior of BPDCN to improve its understanding by both clinicians and pathologists. Case 2 survived significantly longer than the other two cases, suggesting that their treatment was more effective.

Question two: (Case presentation & Discussion) Chemotherapeutic regimens, such as CHOP, VDLD, CAM, and VDCLP, are described without explanations. It would be better to explain these regimens at their first appearance.

Answer:

Case 1 Chemotherapy was administered as the main treatment for BPDCN, but the patient developed bone marrow suppression after VDLD treatment (vincristine 2 mg, intravenous injection, days 1, 8, 15, 22 (1.4 mg/m^2, ≤2 mg each time); daunorubicin 40 mg/m^2, intravenous drip, days 1–3, 15–16; L-asparaginase 6000 IU/m^2, intravenous drip, days 11, 14, 17, 20, 23, 26; dexamethasone 1 mg/kg/day, orally, for 14 consecutive days, reduced by 1/3 on days 15–28). One month later, he was treated with CAM chemotherapy (Cytoxan 750mg/m^2, intravenous drip, day 1, 8 (Uromitexan rescue); cytosine arabinoside 100 mg/m^2/day, intravenous drip, days 1–3, 8-10; 6-mercaptopurine 60 mg/m^2/day, oral, days 1–7), and again showed bone marrow suppression.

Case 2 The subcutaneous nodules subsided after anti-infective treatment but subsequently reappeared and became more severe, gradually involving the limbs and body. She was treated with CHOP (cytoxan 750 mg/m^2, vincristine 1.4 mg/m^2, doxorubicin 50 mg/m^2, all by intravenous drip on day 2, prednisone 100 mg, oral, days 2 – 6; repeated every 21 days) and VDCLP (vincristine 2 mg, intravenous injection, days 1, 8, 15, 22 (1.4 mg/m^2, ≤2 mg each time); daunorubicin 40 mg/m^2, intravenous drip, days 1 – 3, 15 – 16; cytoxan 750 mg/m^2, intravenous drip, days 1, 15 (uromitexan rescue); L-asparaginase 6000 IU/m^2, intravenous drip, days 11, 14, 17, 20, 23, 26; prednisone 1 mg/kg/day, oral, for 14 consecutive days, reduced by 1/3 on

days 15–28) for BPDCN, with improvement of the subcutaneous nodules and a complete bone marrow response.

Case 3 was treated in another hospital. She knew that she had received chemotherapy but did not know the chemotherapy regimen.