Peer Review File

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Reviewer A

1. Although it was described as 'compressed' in the manuscript, did the authors suspect tumor invasion to other organs from preoperative image findings? (Chest wall, lungs, atrium, etc.) ; page 3/Line 72-83.

Reply: From preoperative image findings, we suspect tumor invasion to other organs, such as lung, the right atrium, right pulmonary artery, right superior pulmonary vein, and the great heart vessel.

Change in the text: We added the sentence the revised manuscript.

2. The authors should describe the surgical procedure and findings in more detail. (the size of the wound, where the thoracotomy intercostal space was, and whether there were adhesions in the thoracic cavity.) ; page 3/Line 85-88.

Reply: We chose left lateral position, and the right posterolateral sixth intercostal incision into the chest. The length of the wound was about 30 cm. There were a small amount of adhesions in the thoracic cavity.

Change in the text: We added the sentence the revised manuscript.

3. Long-term follow-up is recommended because SFTs can cause late recurrence. How long do the authors plan to follow-up after surgery?

Reply: A long-term follow-up is mandatory because of the risk of recurrence of SFTs. Although the survival outcomes revealed the 5-year RFS and OS of benign patients were all 100%; however, the 5-year RFS and OS of malignant patients was 58.3% and 66.7%, respectively. A malignant SFTs recurrence has been reported 17 years after surgical resection. Thus, Postoperative follow-up with CT is recommended every 3–6 months for 2 years and then annually. However, for malignant tumors with a high risk of recurrence, closer clinical follow-up is recommended.

Change in the text: We added the sentence the revised manuscript.

Reviewer B

Please provide histological and immunohistochemical photos with better quality, I cannot see with detail the histological photos.

MDM2 was tested?

Reply: The submission system cannot upload files larger than 25M, so the picture quality was not clear enough. We changeed the original histological and immunohistochemical photo tiff, thus we can upload it to submission system. MDM2 was not tested in our study.

Change in the text: NA.

Reviewer C

The reading of this case report is remarkably interesting. Studying BRCA1 mutation in those tumours should be done in the future. I have provided some minor comments as follows:

1. Case presentation:

Page 3: Can you specify if necrosis was seen in histology of the lung biopsy?

Reply: Necrosis was not seen in histology of the lung biopsy in our case.

Change in the text: We added the sentence the revised manuscript.

2. Discussion:

Page 4 – line 110 to 113: In epidemiologic presentation of solitary fibrous tumour, specify that most of solitary fibrous tumour are benign and that there is, for now, no risk factor identified as specified in Penel and al. review of literature (Sarcoma, 2012).

Reply: Most of solitary fibrous tumour are benign. For malignant SFTs, as reported by Penel et al., they are hypercellular and display at least focal moderate-to-severe nuclear atypia. Malignant SFTs often have infiltrative margins with surrounding tissues, have high mitotic count (≥4 mitoses per 10 high-power fields), and display cellular pleomorphism and tumor necrosis.

Change in the text: We added the sentence the revised manuscript.

Page 5 and 6: In pathological part: Provide the definition of NAB2-STAT6 fusion (its location: locus 12q13, and its trouble to be identified by FISH analysis). State about the link between this fusion and STAT6 expression in immunochemistry especially its high

sensitivity and specificity as it is seen in meningeal solitary fibrous tumour.

Reply: We provided the definition of NAB2-STAT6 fusion and state the link between the NAB2–STAT6 gene fusion and STAT6 nuclear expression for solitary fibrous tumor.

Change in the text: We added the sentence the revised manuscript.