Peer Review File

Article information: https://dx.doi.org/10.21037/apc-23-5

Reviewer A

Accept.

Reviewer B

The submitted manuscript present a very interesting case. There are some minor issues to be addressed.

1. The patient had a history of hypoparathyroidism and hypothyroidism. Whether this patient had a MEN syndrome should be addressed.

   Reply 1: Multiple endocrine neoplasia type 1 was eliminated. In fact, the other major lesions of this syndrome were missing: pituitary MRI was normal, especially, it didn't show a pituitary adenoma and our patient hadn't primary hyperparathyroidism before thyroidectomy. Our patient actually was operated for thyroid nodule suspected of papillary carcinoma on fine needle aspiration cytology and the definitive histopathological examination concluded to a macrovesicular adenoma without histological signs of malignancy. After thyroidectomy, our patient presented with post-surgical hypoparathyroidism and serum calcium, serum phosphorus, parathormone and 25- hydroxy vitamin D were all normal before total thyroidectomy.
   Changes in the text: we added these data in our manuscript (see Page 1, highlighted lines 28,29 and 30, and see Page 2, highlighted lines 57,58,59 and 60)"

2. The patient's clinical course appeared to be a quite aggressive one. I am very surprised that this patient did not have the chance of having the surgical resection. I suggest describing the diagnosis and management of PE and infection and other diagnostic workups in more detail. Did the care team think the PE and infection were related to the paraneoplastic cushing syndrome? We can learn a lot from managing similar cases.

   Reply 2: Yes, I do agree that the clinical course of our patient was very aggressive and also the initial clinical presentation was very severe in relation to this paraneoplastic hypersecretion of cortisol. In fact, while locating the tumor to guide the surgical procedure and before the operation, unfortunately, our patient presented acute respiratory distress syndrome related to bilateral massive pulmonary embolism requiring her transfer to intensive care. In addition, our patient developed recurrent respiratory and urinary tract infections treated with appropriate antibiotic therapy. For pulmonary embolism and recurrent infections, our medical team does consider the role of paraneoplastic Cushing's syndrome in the appearance of these complications since excess cortisol increases the risk of infection, thromboembolism and other complications. Otherwise, pulmonary embolism followed peripheral venous thrombosis of the right lower limb which was related to the femoral venous catheter to correct the severe hypokalemia despite our patient was on preventive anticoagulation.
   Changes in the text: we have modified our text as advised (see Page 2, highlighted lines 62, 63,64,65,66 and 67)