Peer Review File
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Reviewer A

This review seems to be well-designed and well-performed. But, I suggest making one more efforts that need to be addressed.

Comment 1. PAGE 10, line 200-229
Considering the anti-reflux medical treatment, it would be better to describe or suggest the minimum or maximum period time of treatment although there was little evidence indicating optimal treatment duration in GERD-associated cough.
Reply 1: We appreciate the professional comments from Reviewer 1 and have revised the manuscript as suggested.
Changes in the text: We have added the description regarding the duration of acid suppression treatment to the revised manuscript (See page 14, line 261-270).

Comment 2. PAGE 10, line 230-256
Other than neuromodulators, including baclofen and gabapentin, It would be nice to add more evidence (medication) targeting both acid and non-acid reflux.
Reply 2: We have revised the manuscript as suggested.
Changes in the text: We have added the relevant content to the revised manuscript (page 15, line 279-288).

Comment 3. PAGE 11, line 225-227.
You mentioned that acid suppressive therapy is currently the second-best option for cough due to weakly acidic reflux. If then, I'd like to ask your opinion what the first-best option for cough due to weakly acidic reflux. It needs to be clarified.
Reply 3: We have revised the manuscript as suggested.
Changes in the text: We have added our opinion regarding the first-best option for cough due to reflux in the revised manuscript (page 14, line 255-256).

Comment 4. PAGE 13, line 271-280.
The content presented in the conclusion somewhat needs to be modified. Especially you need to present more additional descriptions regarding the neural crosstalk for the GERD-associated cough between tracheobronchial-esophageal reflex and esophageal-tracheobronchial reflex.
Reply 4: We have revised the manuscript as suggested.
Changes in the text: We have modified the content in the conclusion (page 17, line 322-328).

Reviewer B

This is a report of the personal views on the pathogenesis and management of cough associated with gastroesophageal reflux disease (GERD). The report covers a wide range of the pathogenesis and management of GERD-associated cough, which should be of interest to readers. However, I would like to offer some comments on this report.

Major comment

Comment 1. The tracheobronchial-esophageal reflex theory is an attractive hypothesis explaining why only some patients with GERD present with chronic cough and others do not. However, the evidence for the existence of this pathway is still limited and the author needs to tone it down.

Reply 1: We are glad that the referee found the report interesting. We agree that the evidence for the existence of the tracheobronchial-esophageal reflex is still limited and have made changes to describe this cautiously as suggested.

Changes in the text: See page 3, line 31, page 7, line 106-114, and page 17, line 323.

Minor comments

Comment 1. It would be helpful if DeMeester score could be provided in a supplementary file.

Reply 1: DeMeester score was a common parameter to measure a global esophageal acid exposure, and is now replaced by AET due to his poor repeatability. We do not think it is necessary to be provided in a supplementary file since it is easy to be found in the literatures.

Changes in the text: We have described DeMeester score and added the relevant literatures in the revised manuscript instead of in a supplementary file (See page 10, line 166-170 and page 11, line 191).

Comment 2. According to the author, only the Chinese cough guidelines include esophageal reflux monitoring; it would be interesting to add any information on the proportion of patients with suspected GERD-related cough who were monitored for esophageal reflux, comparing the proportion in China with that in other countries.

Reply 2: We have revised the manuscript as suggested.

Changes in the text: We have added the relevant statement regarding the clinical application of reflux monitoring to the revised manuscript (page 10-11, line 178-185).