Peer Review File

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Reviewer A:

Comment 1: Introduction should be maintained brief and concise, and this detailed explanation is not warranted.
Reply 1: Thank you for your comments. We revised the introduction to follow your suggestion, as required.
Changes in the text: The following paragraphs were cancelled from the revised version of the manuscript. Lines refer to the original version of the paper.
Lines 50-54 'These lesions may represent a diagnostic challenge due to their clinical and radiological characteristics – such as the cystic appearance – shared with other pathological entities. Survival of patients affected by CPA is worsened in case of associated congenital cardiac diseases, lung hypoplasia or following the development of pulmonary hypertension or systemic infection.'
Lines 64-66 'Patients affected by intralobar PS may develop recurrent pneumonia, hence, the differential diagnosis of these lesions is frequently challenging.'
Lines 75-77 'They are considered in the differential diagnosis among other mediastinal or parenchymal abscessual lesions, in particular in case of superinfection; however, BCs usually present as single loculated structures.'
Lines 83-84 'In fact, it is reported that in about a half of the patients affected by intralobar PS and in most of those with BC these lesions are found over 20 years of age.'

Reviewer B:

Comment 1: How did you differentiate the hypovascularized parenchyma during the surgery? Any landmark? Visualization only?
Reply 1: Thank you for your observation. In this case, the pulmonary sequestration (PS) was delimited from the rest of the left lower lobe by the presence of an accessory fissure, that allowed to remove the PS by means of a wedge resection.
Changes in the text: We specified in the case description that the pulmonary sequestration was demarcated from the rest of the left lower lobe by an accessory fissure. Moreover, an intraoperative picture of the PS was included in the revised version of the manuscript (Figure 2A).

Comment 2: I agree with the conception that VATS is a reasonable approach to this kind of disease. Please specify what kind of stapler was specifically used to the aberrant arteries. Also, do you have any comments on how far away from the root of the aorta?
Reply 2: We used a curved tip 30 mm-vascular reload stapler to separately divide the aberrant arteries as close as possible to their origin from the aortic wall, avoiding to leave a long stump.
Changes in the text: This information was updated in the description of the case.

Comment 3: Do you have any comment on the duration of following-up?

Reply 3: We thank the reviewer for this comment. There is not a consensus about the appropriate duration of follow up after resection for PS and BC. However, several authors demonstrated that long term recurrence-free survival is achievable in case of radical resection of these lesions.
Changes in the text: We added a comment about long term follow up and related factors after excision of PS and BC in the discussion.

Reviewer C:

Comment 1: The author discusses VATS, but with the recent proliferation of single-port VATS and RATS, it is necessary to discuss these as well. There are already a few reports of single-port VATS or RATS for congenital pulmonary anomalies.
(Ann Thorac Surg. 2021 Apr 27;S0003-4975(21)00752-9.) (J Thorac Dis. 2016 Jan;8(1):E148-51.) etc.
Reply 1: We agree with the reviewer that uniportal VATS (U-VATS) and robotic technology are increasingly used with favourable results in the treatment of congenital pulmonary lesions.
Changes in the text: We included a comment about the referenced experiences of congenital pulmonary lesions treated by means of U-VATS and robotic surgery in the discussion, as required.

Comment 2: This patient had a large dysfunctional lung (line 128: 5 x 6 x 4 cm), but a wedge resection was performed. The text should clearly state the rationale for performing a wedge resection. Certainly, preservation of lung function should be considered for young patients. However, if part of the dysfunctional lung remains, there is a possibility of malignant transformation. If ICG injection or other methods are not used, the surgical technique should be carefully determined.
Reply 2: Thank you for your observation. In this case, the sequestrated parenchyma was demarcated from the rest of the left lower lobe by the presence of an accessory fissure, that allowed to remove the PS by means of a wedge resection.
Changes in the text: We specified in the case description that the PS was delimited from the rest of the left lower lobe by an accessory fissure. Moreover, an intraoperative picture of the PS (Figure 2A) and a comment about the role of wedge resection in case of PS surgery were included in the revised version of the manuscript.

Comment 3: CT images show abnormal blood vessels, but no CT shows the size of the non-functioning lung. The author should additional CT images if possible.
Reply 3: Thank you for this comment. We added a CT scan image in Figure 1 (panel B) showing the abnormal hypovascularized parenchyma in the left lower pulmonary lobe.
Changes in the text: We changed Figure 1 caption according to the panel included in the revised version.

Comment 4: Please add the following to the Figure legend (Figure 1). (line 293: … to the descending aorta [(A)].)
Reply 4: We thank you for noticing this lack in the text.
Changes in the text: Reference to panel (A) was added to the figure legend.