**Response to Editors and Reviewers:**

**1# Editors**

**A1**. Your article has 4 authors, and our publication rules state that case reports must have a maximum of 3 authors. We suggest you select one author to be included in the “acknowledgements” section of your article for publication to be possible.

**B1.** As recommended, we moved one of the authors with least contribution into acknowledgments section.

**A2**. You referenced 16 publications, and the maximum allowed for a case report is 15. We will not, however, be too rigid about this issue.

**B2.** Thank you for your understanding and tolerance toward one extra reference.

**A3**. You have not submitted an informed consent from the patient for the publication of their clinical information. The images you have submitted do not, per se, allow the identification of the patient. However, the publication of these images along other descriptives of the patient such as “61-year-old female“ and “an incidentally found congenital tracheal defect that has not been previously reported in humans” as well as the names and affiliations of the authors may hinder patient anonymity. For this reason, we urge you to send us an Informed Consent form signed by the patient of their legal representative as soon as possible. This form may be in any format other than the AMP template, but there must be no doubt that the patient or their legal representatives know that this information will be published in electronic or physical format and they will be available in any part of the world.

**B3**. Dear Editors, we have an old informed consent dated back to year 2017 when patient was still at the hospital after her surgery. The form is in Polish and states that patient agrees to publish in medical literature her photos and medical exam results. Is it enough? Or do we need to ask for more specific consent?

**A4**. The title and abstract of your article must also be submitted in Portuguese for its publication to be possible. You may seek information about translation services within the Portuguese Embassy or Consulate in your region.

**B4**. Dear editors, we provide Portuguese translation and we acknowledge a medical student who helped in translating in *Acknowledgments* section.

**A5.** We ask that you include in your submission a short title for your article.

**B5.** As recommended, a short title was added. “Double-lumen trachea in human – case report.”

**A6**. You do not state or deny any funding you may have received for the elaboration of this work, and neither have you stated or denied any conflict of interest. We ask that in your submission you may do so.

**B6**. As recommended, we added appropriate statement: “The authors declare that there is no conflict of interest. No funding was received for this project.”

**A7**. The images that you have submitted do not respect our publication guidelines, which state that images must be in BMP, EPS, JPG, PDF or TIF format, with 300 dpi resolution and at least 1200 pixel width and height, and must be original images, without any kind of edit work (such as crops, erased patient information, print screens, characters or arrows). Every necessary edition to the images will be performed by the graphic department of AMP. We ask that you submit new imagens as supplementary material to the submission.

**B7**. Dear editors, we added as supplementary material original versions of pictures we have.

The editors would like you to address the following formal issues, many of them minor but important none-the-less:

**A1.** We ask that you indicate in your manuscript where approximately the submitted figures should be inserted in the final print, for example with “insert figure 1 here”.

**B1**. Done.

**A2.** We ask that you uniformize the references throughout the manuscript (sometimes consecutive references are separated by comma and other times by dash).

**B2**. Done. Now two consecutive numbers are separated with comma. When there is range, including 3 references then there is a dash. Hope now it’s acceptable.

**A3**. “et al” must be used only when the reference has more than 6 authors, and when so 6 authors must be named before “et al”. We ask that in reference 3 you follow this rule.

**B3**. Done.

**A4**. References 3 and 4 should include publication year.

**B4.** Done.

**A5**. References 1, 5, 6, 7, 8, 10, 12, 13, 14, 15, 16 must not include DOI or website.

**B5**. Done.

**A6**. References must not have their title in italic or in parentheses.

**B6**. Done

**A7**. Author initials in references should not be separated by period.

**B7**. Done

**A8**. References 13-16 are formate in APA style. References should be formatted according to the AMP publication rules.

**B8**. Done.

**A9**. The second paragraph of the “Introduction” section should instead be included in the “Case Report” section.

**B9.** Done.

**A10.** In the “Case Report” section, in “A CT scan perforemd” it should read "A CR scan performed”.

**B10.** Corrected.

**A11.** In the “Discussion” section, in “in which case - are usually” it should read "in which case are usually”.

**B11.** Corrected as recommended.

**A12.** In the “Discussion” section, in “Tracheal bronchus represents one of the congenital anomalies, that rarely” it should read “Tracheal bronchus represents one of the congenital anomalies that rarely”.

**B12.** Done.

**A13.** In the “Discussion” section, in “instead of running to superior lobe of the lung - rejoined the trachea” it should read “instead of running to superior lobe of the lung, rejoined the trachea”.

**B13.** Done

**2# Reviewer 1**

Reviewer 1 has made the following comments:

A1. In general the article is interesting and well written.

B1. Dear reviewer, thank you for positive opinion.

2. As a clinical case of an extremely rare pathology, the text alerts to the various differential diagnoses of patients with dyspnea and etiological factors of tracheal malformations.

**A3**. The article in my opinion presents a small error in its presentation and exposure. The described malformation is presented as ("A tracheal septum as a congenital defect has not been previously reported in humans.") the first case of tracheal septum described in humans. There is however a published clinical case of a tracheal septum in an 11-month-old child dated April 2019 (DOI: 10.1164 / rccm.201805-0891IM) - "Congenital Vertical Tracheal Septum Misdiagnosed as Laryngomalacia." American Journal of Respiratory and Critical Care Medicine, 199 (7), pp. 917-918 "

**B3**. Dear reviewer, thank you for your suggestion. We are grateful for sending us this reference. Same time we feel a bit disappointed as we had a chance to publish it before April 2019 and then it would be first reported case in human. We had just bad luck. Anyway, still it is a first report of this defect in adult person what is even more extraordinary than its presence in the new-born. To adjust it, we changed the sentence so that instead of “in humans” we write

**A4.** Title: The title is too long and descriptive.

**B4.** Thank you for your remark. We made the tile shorter.

**A5**. Abstract: For a clinical case the abstract is somewhat extensive, focusing on details that are not essential for understanding the case, namely "during nephrectomy, laparoscopy or hysteroscopy."

**B5.** Dear reviewer, thank you for your remark.As recommended, we cut out this part from manuscript making it shorter.

**A6**. Introduction: It is adequate and succinct. However, I do not think it necessary to place the description of the microlaryngoscopy to describe the tracheal septum at this stage of the article. ("Mircolaryngoscopy performed because of patient's subglottic stenosis revealed a vertical tracheal septum forming double-lumen trachea.")

**B6.** This part was moved to Case Report section.

**A7**. Methods and Results: The clinical case is explicitly described. The article presents a small english error in the word "bronchofiberoscopy".

**B7**. Dear reviewer, according to medical dictionary bronchofiberoscopy is a correct spelling. If you prefer to have it in another spelling, we agree so that editor can adjust it and change it accordingly.

**A8**. Discussion: Differential diagnoses are explained sequentially, completely and clearly.

**B8**. Dear reviewer, thank you for your positive opinion.

**A9.** The different treatment modalities available for this type of disease were not explored and when they should be used, namely surgery.

**B9**. As recommended, we added a few sentences regarding management of subglottic stenosis. When it comes to tracheal anomaly (septum) no surgery was performed, as after the dilatation, the patient is asymptomatic.

**A10**. References: They are adequate and up-to-date. They do not follow the AMP style and should be reviewed: "Zach, M. S., & Eber, E. (2001). Adult outcome of congenital lower respiratory tract malformations. Thorax, 56 (1), 65-72. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/11120908 "

**B10**. References were changed according to editors recommendations.

**A11**. Figures: They are descriptive and appropriate to the clinical case. (EDITOR NOTE: despite this reviewer note, please address editor notes about figures).

**B11**. Dear reviewer, Thank you for your opinion.

**A12**. Acknowledgments: No source of funding or conflict of interest has been identified or excluded by the authors. (EDITOR NOTE: please address reviewer 1 point 12., reviewer 3 point 11. and editor points about funding and conflicts of interest together).

**B12**. Issues fixed in aforementioned editorial points.

**A13**. Length: The length of the manuscript is adequate.

**B13**. Dear reviewer, Thank you for your opinion.

**A14**. Presentation: The manuscript is presented in a clear and logical manner.

**B14**. Dear reviewer, Thank you for your opinion.

Reviewer 2 has made the following comments:

1. The surprise of the findings during the laryngotracheoscopy is understandable but the clinal history of this patient does not suggest a congenital malformation:

**A1.1.** Why does the patient has a subglottic stenosis? what is the origin and etiopathogeny?

**B1.1** The most probable etiology of the subglottic stenosis in this particular patients were numerous repeated intubations. As the patient belongs to risk group (adult female, Caucasian ethnicity), idiopathic tracheal stenosis cannot be excluded. We want emphasize again that subglottic stenosis and tracheal defect are considered as two separate entities in this patient.

**A1.2.** What was the cause of dyspnea? Why didn’t it appear before?

**B1.2.** The dyspenea appeared simultaneously with mild upper airways infection that led to decompensation and occurrence of symptoms at this particular time. The dyspnea was rather associated with developing subglottic stenosis than as we consider congenital tracheal abnormality.

**A1.3**. What is your suggestion for symptoms onset at this age? And what were the precipitant causes for symptoms?

**B1.3.** Same answer as in point B1.2.

**A1.4.** How can you justify why the tracheoscope did not pass through the stenotic area and 3 previous endotracheal tubes for 3 different surgeries did it, without any report of difficulties or an emission of a difficult air way alert card? It seems more as an acquired pathology than a congenital one.

**B1.4** We consultedanaesthesiologist and surgeonwho were taking care for this patient. Our conclusion is that the congenital tracheal septum is located under the acquired subglottic stenosis. Before the stenosis had developed, there was enough space to secure and place endothracheal tube under the glottis. Even if the tube was pushed deeper it was possible to pass for the tube, cause the wider branch in the anomaly has a approximately 12mm (the narrowing has 7 mm diameter, the remaining canal had approximately 13 mm so a typical tube for women sized 10-11mm would still pass. Here the problem with intubation was caused by acquired subglottic stenosis.

2. It would also be interesting to describe:

**A2.1**. What kind of dilation method had been used?

**B2.1**. In this patient, mechanical dilatation with balloon dilatators was used with good results.

**A2.2.** “A bronchofiberoscopy and an observation for proliferative diseases and microinjuries is to be performed.” Was it performed? And which are the results?

**B2.2.** A control bronchoscopy was performed and showed good result of previous dilatation as the ENT surgeon was happy with the size of the tracheal lumen. As visualized during the surgery, the recorded anomaly was still present and unchanged.

**A3.** Finally, you can not exclude that the subglotis and tracheal lesions are consequence of the previous intubations associated, or not, with infection.

**B3.** We can definitely consider intubations and infection as a probable causes of subglottic stenosis. It is less probably that those factors would lead to creation of firm and stable septum resembling cartilage. However, as pointed, we are unable to prove it as no previous chest or neck CT is available.

Reviewer 3 has made the following comments:

1. RELEVANCE: This manuscript describes a congenital tracheal variation. The authors should further develop the clinical relevance of this finding and how its recognition will help physicians improving their practice or their approach to these patients.

**A2**. ORIGINALITY: This paper points out a congenital tracheal defect that has not been previously reported in humans. As result it adds knowledge regarding congenital variations of the trachea.

**B2**. Dear reviewer, thank you for your opinion.

**A3**. MISCONDUCT: There is no evidence of misconduct on the part of the authors. (EDITOR NOTE: funding and conflicts of interest disclosures must still be sent).

**B3**. Funding and conflict interest statements provided.

**A4**. Title: Informative. It reflects the content of the article succinctly. (EDITOR NOTE: please address reviewer 1 point 4. and reviewer 3 point 4. together).

**B4**. Title edited as stated in reviewer1 point 4.

**A5**. Abstract: The abstract reflects the content of the manuscript. It is structured, clear and concise. (EDITOR NOTE: please address reviewer 1 point 5. and reviewer 3 point 5. together).

**B5**. Abstract changed as recommended.

**A6**. Introduction: The objectives are clearly described. However, the authors do not present the rationale for the description of the clinical case or justify why the case should be published at AMP (ie what is its educational message). (EDITOR NOTE: please address reviewer 1 point 6. and reviewer 3 point 6. together).

**B6**. As requested, we added rationale why to publish this case report.

**C6**. “In this article, we present a case of a double-lumen trachea. This is an extremely rare finding and it has not been described in an adult before. Thus, it is crucial to share our experience in management of patient with aforementioned tracheal malformation detected in adulthood.”

**A7**. Description of the clinical case: The description of the clinical case is performed adequately, briefly and clearly. The submitted figures are illustrative of the findings and present quality for publication. The confidentiality of the data is assured. (EDITOR NOTE: informed consent must still be sent).

**B7**. Informed consent provided and submitted with revision.

**A8**. Discussion: The authors do not explain the relevance of the results or highlight the message of the clinical case. (EDITOR NOTE: please address reviewer 1 point 8. and reviewer 3 point 8. together).

**B8**. Dear reviewer, as recommended we added two sentences discussing the relevance of this case report.

**C8**. “Although this anomaly is a rare finding in humans, it is important for clinicians to be aware of its presence. This case report suggests that double-lumen trachea is not a life threatening condition and it can be managed with “watch and wait” approach.”

**A9**. References: The literature review was considered adequately. However, the authors exceeded the maximum limit of 15 references and the bibliographic references do not follow AMP’s style (authors should review the journal publication guidelines). (EDITOR NOTE: please address reviewer 1 point 9., reviewer 3 point 9. and editor points about references together).

**B9**. The reference list was reviewed as recommended by editors.

**A10**. Figures: The figures are clear and legible. They are correctly identified in the main text. (EDITOR NOTE: despite this reviewer note, please address editor notes about figures).

**B10**. Dear reviewer, thank you for your opinion.

**A11**. Acknowledgments: The authors do not identify or exclude the use of any source of funding or the existence of conflicts of interest. That must be done clearly. (EDITOR NOTE: please address reviewer 1 point 12., reviewer 3 point 11. and editor points about funding and conflicts of interest together).

**B11**. Funding and conflict interest statements provided as requested.

**A12**. EXTENSION: The manuscript has an adequate extension.

**B12**. Dear reviewer, thank you for your opinion.

**A13**. PRESENTATION: The manuscript is presented in a clear and logical manner.

**B13**. Dear reviewer, thank you for your opinion.

**A14**. In the “Case report” section, the sentence “Patient's history however, does not include previous difficulties with intubation (during nefrectomy, laparoscopy or hysteroscopy), an episode of tracheitis and pneumonia earlier that year.” Should be grammatically reviewed.

**B14**. Thank You for your precious remark. The sentence was corrected and reviewed grammatically.

**A15**. In the “Discussion” section, the sentence “A review of the literature on such anomalies suggests tracheal bronchus, obstructive pseudomembranes as a complication of endotracheal intubation or infections, pleural junctional line that could give a false impression of a septum in diagnostic imaging or tracheal secretions.” Should be grammatically reviewed.

**B15**. Dear reviewer, as requested we modified this sentence so it works better grammatically.