**Reviewer’s report**

**Title:** Isolated Langerhans cell histiocytosis of hypothalamic-pituitary region: A case report

**Version:** 0  **Date:** 15 Oct 2019

**Reviewer:** Shinsaku Imashuku

**Reviewer's report:**

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**Major comments**

This case is not rare. In this manuscript, the authors must focus more on isolated CNS-LCH lesions causing CDI (incidence, natural course, treatment response, etc.). Additionally, the most critical question is why the enlarged pituitary stalk was masqueraded as that in lymphocytic hypophysitis. Any specific and differential MRI images for the lymphocytic hypophysitis distinct from those in LCH? Lymphocytic hypophysitis is commonly associated with autoimmune polyendocrine syndrome (APS, types 1-4). How about in this case? The statement that in LCH, CNS lesion is more unusual and LCH of CNS lesion frequently manifests as anterior pituitary hormone deficiency (APHD) is not correct, which should be revised.

**Minor comments**

1. **negative should be negative**

2. **the pituitary was told to be diffusely enlarged (1.3*0.8cm); what the normal or reference size?**

3. **It seems to be very difficult to tell from Fig.1 ab that the high signal area of the posterior pituitary had shrunk, and the enhancement of the posterior pituitary gland was obvious but still uniform.**

4. **signal of the rest of hypothalamus were not different; compared to what?**

5. **gene detection was recommended to exclude B-cell lymphoma; what is gene detection?**
6. levothyrocine was given; why? Did the patient have hypothyroid status?

7. in people with LCH; in patients with LCH?

8. And after continued the treatment, the pituitary stalk nodular thickening was continuous enlarged; In fact, in this case no treatment (chemotherapy) was given.

9. typical MRI changes for lymphocytic hypophysitis; describe in detail what images are typical for the disease and not for LCH.

10. conformed should be confirmed

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