Reviewer 1:

The Authors describe a unique case, the first so far in literature, of BPDCN patient treated with a clofarabine based regimen. I understand that this is the first evidence of some degree of efficacy of such regimen in this setting. However, the efficacy was partial, with 6 months of morphological remission (MRD positive). In addition, toxicity was quite severe. As I’m not really surprised that clofa/araC might be somehow effective in a myeloid tumor, I do not see at present a real interest in this case. The collection of a small series of 2-3 cases (being the disease very rare) might be a nice idea.

Reviewer 2:

The authors describe a case of blastic plasmacytoid dendritic cell neoplasms treated palliatively with the combination of clofarabine and cytarabine.

It is an interesting, novel report, however, some (minor) points should be taken into account:

The authors claim that this combination is a "suitable option" for patients ineligible for high-dose therapies. However, on the other hand, they state, that "multiple grade IV therapy-related adverse events" had occurred. This is a discrepancy and should be corrected especially an opportunistic infections may also be due to the underlying malignancy.

Cardiac dysfunction should be explained more in detail (echocardiography etc).

The same holds true for "hepatic dysfunction" as it is most likely related to the treatment

Reviewer 3:

The case report describes a 55-year-old woman with chemotherapy-related BPDCN, who showed morphological complete remission after clofarabine and cytarabine treatment. However, the patient relapsed and eventually died due to thrombocytopenia-induced intracranial bleeding. The observation that the patient had a clinical response to clofarabine and cytarabine treatment, where intensive anthracyclin-based regimen and stem cell transplant could not be performed is valid information for clinicians in the field of Hematology. However, there are a few points that need to be addressed by the authors:

1. The abstract should provide information that the PBDCN could be therapy-induced in this patient. Furthermore, the fact that the patient relapsed and eventually died is also valid information for this case report.
2. In the introduction it is stated that 5q alterations predominate, but also 12p and 13q abnormalities occur frequently and should be mentioned (review of Riaz et al, 2014).

3. Dexamethasone dosage is not complete 10 mg?.

4. The genetic lesions mentioned in the discussion should include IKZF1 and the genes should be written in Italic.

5. Reference #14 is not updated correctly (Leukemia 2014).

(end)