Comment 1: The introduction is too long, please, trim it down accordingly and state clearly the endpoint of the study.

Reply 1: We have shortened the Introduction section, which only consists of two paragraphs now (around 400 words). Aims of the study was clearly stated as following. Changes in the text: In this study, we performed a complete single-center retrospective analysis of a group of 25 patients with COVID-19 disease in terms of epidemiological data, laboratory tests, clinical outcomes, radiological features, and medical treatments. This descriptive study gives an overall clinical understanding of the COVID-19 patients in a prefecture-level city and provides a valuable experience in the prevention and treatment of COVID-19 disease in China.

Comment 2: I have noticed that ferritin levels increase from admission to discharge. Is there an explanation for that?

Reply 2: Ferritin is a major intracellular iron storage protein in all organisms. It binds free ions of the trace element, neutralising its toxic properties and increasing its solubility. Hyperferritinemia has been associated with increased illness severity and adverse outcomes, including COVID-19, which might lead to cytokine storm. In this study, we observed a slightly higher ferritin level for patients from admission to discharge. There are several possible explanations for this phenomenon: 1) the ferritin data for all the patients from admission (n=25) to discharge (n=25) is not complete, which might not reflect the real trend of the indicator; 2) when patients discharging from hospital, they only need to meet the criteria of no fever, two negative PCR test, and well-adsorbed lung lesions. However, these patients are still in recovering stage and there might still be some indicators out of normal range. For a detailed distribution of the ferritin levels in patients, please refer to the provided figure on the upper right of this paragraph.

Comment 3: Please, provide more reference and details regarding the traditional Chinese medicine used in this study.

Reply 3: We have looked into the details of Lianhuaqingwen capsules and added the following paragraph into the discussion section of the manuscript. Extra references were also added for supporting the positive roles of the TCM in the treatment of COVID-19 diseases. Changes in the text: According to several clinical trials in terms of its efficacy and safety toward SARS-CoV-2 infections, LH capsules could be considered to ameliorate clinical symptoms of Covid-19 and shorten the duration of viral shedding (10-12). Previously, a bioinformatic analysis constructed an influenza-related protein–protein interaction (PPI) network, which revealed that there were 15 main effective components in the medicine while 7 of them were further experimentally validated to have antivirus efficacy in vitro (13). As for SARS-CoV-2 infection, it was postulated that key components in LH capsules could block the binding of SARS-CoV-2 with
the angiotensin converting enzyme and ameliorate lung injury via the suppression of oxidative stress and apoptosis, though more experimental evidences were required (10).”

Comment 4: Was there any analysis done regarding markers of prognosis in this cohort? I anticipate that the cohort was comprised from patients with mild disease, right? If not please state how disease severity was decided and provide details of the oxygen therapy used.

Reply 4: We did not identify reliable markers of prognosis due to the limited number of patients. The severity of all the patients have been reported in the Supplementary Table 1. According to the clinical records, patients XYFY-001 and XYFY-013 were in severe conditions including acute respiratory distress syndrome (ARDS) and respiratory failure (RF). As for these two severe patients, both of them received mask oxygen inhalation and mechanical ventilation. Patients XYFY-025, XYFY-026, XYFY-027 were patients with very mild symptoms while other cases were in regular conditions of COVID-19 disease.

Comment 5: The discussion is rather boring and without an extended literature review. Please, revise accordingly.

Reply 5: We have revised the discussion section as suggested by the reviewer. We added two parts into the discussion, the one about abnormal ferritin level and the one in terms of traditional medicine, which were highlighted in light yellow.

Changes in the text:
1) As for ferritin, it is a major intracellular iron storage protein in all organisms, which binds free ions of the trace element, neutralising its toxic properties and increasing its solubility. High level of ferritin has been associated with increased illness severity and adverse outcomes, including COVID-19, which might lead to cytokine storm. In this study, we observed a slightly higher ferritin level on average for patients from admission to discharge. The possible explanations for this abnormality include 1) the ferritin data for patients from admission to discharge is not complete, which might not reflect the real trend of the indicator and 2) when patients discharging from hospital, they only need to meet the criteria of no fever, two negative PCR test, and well-adsorbed lung lesions. Thus, these patients are still in recovering stage and there might still be some indicators out of normal range.
2) It is noteworthy that some of the cured patients also received the treatment of LH capsules, a traditional Chinese medicine (TCM). According to several clinical trials in terms of its efficacy and safety toward SARS-CoV-2 infections, LH capsules could be considered to ameliorate clinical symptoms of Covid-19 and shorten the duration of viral shedding (10-12). Previously, a bioinformatic analysis constructed an influenza-related protein–protein interaction (PPI) network, which revealed that there were 15 main effective components in the medicine while 7 of them were further experimentally validated to have antivirus efficacy in vitro (13). As for SARS-CoV-2 infection, it was postulated that key components in LH capsules could block the binding of SARS-CoV-2 with the angiotensin converting enzyme and ameliorate lung injury via the suppression of oxidative stress and apoptosis, though more experimental evidences were required (10).

Reviewer B

Comment 1: This retrospective study provides a descriptive report on 25 patients that were admitted to one of the hospitals in Xuzhou, China. The authors provide a fairly well-written manuscript with attention to detail. They have provided substantial data on the patient demographics, symptoms, course in hospital, and treatment algorithms. These data represent male and female (15 and 10,
respectively) patients who were admitted and treated during the period of January 26-February 13, 2020. The authors have used the STROBE checklist for observational studies as an outline for their manuscript. There are some suggestions that should be considered to make the manuscript stronger and more suitable for publication. See below:

Reply 1: Thanks for the reviewer’s comments. We have gone through the manuscript and revised the manuscript accordingly based on the suggestions. For details, please see our point-to-point response below.

Comment 2: We know that the disease course is worse in patients with hypertension and cardiovascular disease. The authors refer to normal blood pressure as “140/90” when this would in fact, be stage I hypertension. This is should be addressed in the manuscript.

Reply 2: Sorry for the mistake. We have changed the sentence to 120/80 so the new sentence is as following.

Changes in the text: Blood pressure of most patients are at normal range below 120/80 mm Hg and above 90/60 mm Hg while several patients have Stage I and Stage II hypertension.”.

Comment 3: The authors have not distinguished whether any of their included patients were admitted to the ICU at any time during the hospital admission. They comment that critically ill patients had elevated troponin, but do not discuss this data. Were these patients in the ICU? Are there serial troponins? Given the prognostic value, do they have troponin values for their patient cohort?

Reply 3: Yes. We did measure the troponin levels for the admitted patients, which ranges from less than 3 ug/L to 15.28 ug/L. However, we did not include this parameter in the manuscript. The reason for us to talk about the troponin level is because it was described in the New Coronavirus Pneumonia Diagnosis and Treatment Plan. Besides that, we stated the conditions of all the COVID-19 patients in terms of their severity in Supplementary Table 1, among which two patients were in severe conditions while three patients have very mild symptoms. Others were considered as regular COVID-19 patients. No patients were admitted to ICU during hospitalization. What is interesting is that the two patients in severe conditions has different troponin levels, one at 9.87 ug/L while the other one at <3 ug/L. However, we only had the troponin levels during admission and did have a time-series troponin record. That is why we did not include and discuss this parameter in the study.

Comment 4: Two patients returned to hospital with positive COVID tests again. It would be good to highlight if there were any differences in their lab values. Likewise, it would be good to know if there were patients on wards as well as ICU and to stratify the data to see if there were prognosticators.

Reply 4: As for as we concerned, no differences could be identified between the two cases and other patients. The problem with prognosticators is that we only studied 25 patients in this single-center analysis, which is a comparatively small cohort. It would be unreliable to get biomarkers based on such a small set of study. As we have responded above, there is no patient admitted to ICU in this study.

Comment 5: There should be comment on whether there was any correlation with patient recovery time and lab values or treatment strategies. Given the wide variation in treatments, it should at least be discussed that these data will be uninterpretable without larger cohort sizes.
Reply 5: Yes, we agree. We have added the sentence in the discussion section as suggested by the reviewer.

Changes in the text: In general, the indicators identified in this study with significant alterations could be used as assessment of medical therapy during patient recovery. However, it is rather hard to draw any clear correlation with patient recovery time and lab values or treatment strategies. In fact, given the wide variation in treatments, the lab parameters would be uninterpretable without larger cohort sizes.

Comment 6: The authors should consider the term “resolution” instead of absorption. This was used in the context of inflammation and the lung lesions – separate sections.

Reply 6: We have changed the word “absorption” to “resolution”: 1) This is, patients were discharged when their body temperatures returned to normal for more than 3 consecutive days with improved respiratory symptoms, and pulmonary imaging shows significant resolution of inflammation. 2) Patients received medical treatments by following the official guide of the New Coronavirus Pneumonia Diagnosis and Treatment Plan and were all discharged home for recovering. In addition, chest CT scanning showed continuing resolution of lung lesions for these patients.

Comment 7: Figure 1 is very difficult to see. The authors should find a way to enlarge and improve the quality. Also, do the authors mean U=urine? Urea is written in the legend.

Reply 7: Sorry for the mistake. We have improved the quality of Figure 1, which meets the publication criteria (min. 300 dpi). When the figure is enlarged, it is more clear to see the details. In addition, We have changed the word Urea to Urine.

Comment 8: The authors should specify the temperature at which it was considered a fever. I note a peak body temperature in febrile patients was listed as 37.2, which is not a fever.

Reply 8: Thermometer readings generally indicate a fever for rectal, ear or temporal artery temperature at 100.4 F (38 °C) or higher while oral temperature of 100 F (37.8 °C) or higher. In terms of armpit temperature, 99 F (37.2 °C) or higher could be considered as a fever. In order to make this clear, we added a sentence in Supplementary Table 4 to explain this issue, which states as “In terms of armpit temperature, 99 F (37.2 °C) or higher is considered as a fever”.

Comment 9: In Table 4.2, do they mean Max BP?

Reply 9: Yes. We have changed Max BF(t/m) to Max BP (mm Hg).

Comment 10: The authors should look at the STROBE answers they have provided. The lines listed do not match for critical elements such as funding (line 420 listed but not correct), bias (line 406-409 but not seen) etc.

Reply 10: Thanks for the reviewer. We have double-checked the STROBE answers and revised it to match with the manuscript in terms of funding and bias.

Changes in the text:
Funding Page 18 Line 468-469
Bias Page 17-18 Line 379-449

Comment 11: Finally - the journal should ensure grammar and spelling is addressed. Some sentences
are awkward and limit the impact.

Reply 11: We have gone through the manuscript and asked an overseas collaborator to check the grammar and spelling in order to improve the language quality of the manuscript.