

Peer Review File

Article information: <https://dx.doi.org/10.21037/gs-21-877>

Reviewer A

Comment 1: The running title should be changed according to the main conclusion.

Reply 1: we have modified our text as advised (see Page 1, lines 2)

Changes in the text:

Running Title: A “wait-and-watch” Policy for Patients with Benign Phyllodes Tumors

Comment 2: Introduction line 78, please change to BPT are often indistinguishable from fibroadenoma in ..histologic manifestation "by core needle biopsy".

Reply 2: we have modified our text as advised. (see Page 5, lines 78)

Changes in the text:

BPT are often indistinguishable from fibroadenomas (FAs) in both clinical and histologic manifestations "by core needle biopsy".

Comment 3: Method, Clinical data evaluation, line 98, history of fibroadenoma, please specify clinical/image or pathologic diagnosis?

Reply 3: To be specific, the data of "history of fibroadenoma" was collected from the past medical history of inpatient medical records. Generally speaking, it was clinical diagnosis. It was noted in the text: The clinicopathologic data and clinical outcomes that were evaluated for each case from outpatient and medical records included age, history of fibroadenoma, type of surgery, tumor size, histological characteristics, tumor recurrence, distant metastasis, and patient survival. (see Page 6, lines 94-96)

Changes in the text: N/A

Comment 4: Result, Clinicopathologic features, line 138, According to the table 1, recurrence rate $P=0.002$, please check the data. And the author should explain the difference/definition of recurrence and local recurrence in the Method section.

Reply 4: we have modified our text as advised. (see Page 7, lines 110; Page 8, lines 134)

Changes in the text:

1. Recurrence cases include the cases of local recurrence and distant metastasis.
2. The local recurrence rate was lower for BPT (14.6%) compared with borderline tumors (34.2%) and malignant tumors (58.6%), which showed a statistically significant difference ($P<0.01$)

Comment 5: Result, Pathologic Features, The data of margin status was not shown! Generally speaking, the pathologic report should mention this important findings because this is the key factor for recurrence. The author should explain why their pathologic reports didn't show no this finding.

Reply 5: Thanks for your professional advice. The data of margin status is the key factor for recurrence. However, the margin status was not reported in most of the pathologic reports of Chinese PLA hospital, which was the limitation of our retrospective study.

Changes in the text: N/A.

Comment 6: Discussion, line 238, The author had better discuss the role of RT for benign PT and borderline/malignant separately.

Reply 6: we have modified our text as advised. (see Page 12, lines 234-236)

Changes in the text:

The role of radiation therapy (RT) as an adjuvant method for local control remains controversial(12,49-51). Zeng et al. showed that adjuvant RT for borderline/malignant PT decreased the LR rate in patients undergoing BCS(50). However, Boutrus et al. showed that RT was not suitable for BPT but may improve local recurrence free survival for borderline/malignant PT(52). We did not assess RT as a risk factor due to the limited data and more data are needed for further exploration of this issue.

Comment 7: Table 1, the range of age showed that patient less than 20 years old were enrolled. Would author consider collect the data of adults only? The Methods, Patient enrollment should mentioned it.

Reply 7: Thanks for your professional advice. In fact, all cases given a diagnosis of PTs and resected from January 1, 2006 and April 30, 2020 at the First Medical Center of Chinese PLA General Hospital, were all retrospectively evaluated. Patient enrollment did not consider the range of age.

Changes in the text: N/A

Comment 8: Table2, why author consider age of 40 for variable? Please explain in the corresponding part.

Reply 8: The age of the patients ranged from 11 to 72 years, with a mean of 40 years. The P value of age analyzed in the clinicopathologic features of patients included in the study (Table 1) was 0.02. Therefore, authors further analyzed the association of age with disease free survival time (DFS) by kaplan-Meier survival curves and log-rank statistics.

Changes in the text: N/A

Reviewer B

Comment 1: One clarification would be to better explain the VBS as this is not a technique widely used in all institutions.

Reply 1: we have modified our text as advised. (see Page 11, lines 209-210)

Changes in the text:

VABS is a minimally invasive procedure that can remove lesions under ultrasonography guidance, without re-aim or re-insertion.

Comment 2: Furthermore, I believe that the title could be more specific: something along the lines of "Surgical Technique and Margin status in the Prognosis of Phyllodes Tumors of the Breast"

Reply 2: Thanks for your professional advice sincerely. To be specific, we modified the running title according to the main conclusion.

Changes in the text:

Running Title: A "wait-and-watch" Policy for Patients with Benign Phyllodes Tumors

Reviewer C

Comment 1: This is a good systematic review and meta-analysis article to discuss the surgical management in phyllodes tumors of the breast. But it needs to be partially modified and clarified some points.

Reply 1: Thanks for your professional advice sincerely.

Changes in the text: N/A

Comment 2: In row 50 and all in manuscript, "(P<0.01)", please revised to "(P<0.01)" for consistent format.

Reply 2: we have modified our text as advised.

Changes in the text: see in the whole manuscript.

Comment 3: In row 76, "suggesting that surgical margins less than 1cm (<1cm) are sufficient", please delete "<1cm)"

Reply 3: we have modified our text as advised. (see Page 7, lines 74)

Changes in the text:

suggesting that surgical margins less than 1cm are sufficient...

Comment 4: In row 83, ", instead of re-excision to obtain wide margins", please revised to "wide safe margin".

Reply 4: we have modified our text as advised. (see Page 5, lines 81)

Changes in the text:

..., instead of re-excision to obtain wide safe margins

Comment 5: In follow-up and relapse events, what are the follow-up assessment tool? Breast sono, mammography, CT or MRI?

Reply 5: Thanks for your professional advice sincerely. Generally speaking, breast sono was used to evaluated the recurrence condition.

Changes in the text: N/A

Comment 6: In row 141, "Pathologic diagnoses included 171 benign lesions, 38 borderline lesions and 29 malignant tumors', is repeat sentence in "Clinicopathologic Features", please delete it.

Reply 6: we have deleted it in our text as advised. (see Page 8, lines 138)

Changes in the text:

Pathologic Features

Infiltration tumor borders were seen in 12 patients (5.0 %) and pushing borders were seen in 226 patients (95.0%).

Comment 7: In row 147, "Age was not a significant risk factor for LR ($\chi^2=1.069$, $P=0.301$) or DFS", what is DFS?

Reply 7: the abbreviation of DFS was defined in the Page 7, lines 119: Kaplan-Meier survival curves and log-rank statistics were employed to evaluate disease free survival time (DFS).

Changes in the text: N/A

Comment 8: In row 151, "VABS without other surgical treatments, and 15 (17.2%) had a recurrence. Of 60(25.2%)", there are many errors in 60(25.2%). Please revised to consistent format in whole manuscript.

Reply 8: Thanks for your professional advice sincerely and we have modified our text as advised.

Changes in the text: see in whole manuscript.

Comment 9: In Follow-up and Recurrence, did you have the cases experienced the different histological grade in first VABS or LE and follow-up recurrence?

Reply 9: It was a pity that we did not have these cases. We are glad to further communicate questions about PTs.

Changes in the text: N/A.

Comment 10: In row 185, "which are similar to our own", please revised to "our results".

Reply 10: we have modified our text as advised. (see Page 10, lines 180)

Changes in the text: which are similar to our results.

Comment 11: In row 190, "relevant studies suggest that there may be a partial correlation between them.", what is your suggestion in finding the fibroadenoma as management of PTs or in following up after surgery? Biopsy, excision or just keeping following with sono?

Reply 11: Thanks for your professional advice sincerely. We are glad to further communicate questions about PTs. About the condition of the fibroadenoma as management of PTs or in following up after surgery, we should comprehensively evaluate the patients' condition, including family history, the pathologic condition of tumors and the will of the patients.

Changes in the text: N/A

Comment 12: In row 196, "To our surprise, the size of tumor was not associated with RFS ($P = 0.459$)", what is RFS?

Reply 12: we feel sorry that it's a written mistake. We have modified the RFS to DFS. (see Page 10, lines 191)

Changes in the text:

To our surprise, the size of tumor was not associated with DFS.

Comment 13: In row 191 to 200, “mitoses, tumor border, stromal cellularity, stromal atypia, stromal overgrowth, tumor necrosis, type of surgery, and surgical margin status may be risk factors for LR”, but t histologic grade ($P < 0.01$), type of surgery ($p = 0.006$) and history of fibroadenoma ($P < 0.01$) were significant prognostic indicators for LR in your study was noted. How to explain the different results in risk factors of LR, especially in surgical margin lower than history of fibroadenoma?

Reply 13: Thanks for your professional advice sincerely. In fact, it was associated to statistics. χ^2 test and Fisher's exact test were used to determine the correlations among the variables. Then, Kaplan-Meier survival curves and log-rank statistics were employed to evaluate disease free survival time (DFS). The results showed the possible risk factors. Fhurthermore, multivariate regression analysis was performed to analyze the independent prognostic predictors.

Changes in the text: N/A.

Comment 14: In row 224 to 226, “Therefore, we suggest that VABS or LE can be treated for BPT with small mass, whereas WLE or even mastectomy should be conducted for borderline/ malignant PTs with large mass, just as recommended as current guidelines.” “small mass” is mean tumor size smaller than 3 cm, and “larger mass” is mean tumor size larger than 3 cm, please clear it in your discussion.

Reply 14: we have modified our text as advised. (see Page 12, lines 221)

Changes in the text:

Therefore, we suggest that VABS or LE can be treated for BPT with small mass (<3cm), whereas WLE or even mastectomy should be conducted for borderline/ malignant PTs with large mass (>3cm), just as recommended as current guidelines.