Peer Review File

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Reviewer A:

Great study design.

It may be even better if the authors could provide 1) expected period of patient enrollment, and 2) how the decision to undergo revascularization will be made - based purely on CTP or CT-FFR results? Or other information such as patient symptom, patient' preference, result of invasive FFR or other test will also be considered?

Reply:

1) Thank you for this comment. We agree that it is important to provide detailed information in terms of patient enrollment in protocol. So, we added it as suggested.

Changes in the text: "…… enrollment is planned to be finished at January 2022." (see Page 10, line 387).

2) Thank you for this valuable comment. To avoid bias of treatment guiding, the decision of whether to undergo revascularization will be made solely according to the results of ICA and/or invasive FFR (in necessary cases, determined on-site by interventional cardiologists), without considering the results of CT-MPI and CT-FFR.

Changes in the text: "Further treatment strategy will be independently determined by interventional cardiologists according to the results of ICA and/or invasive FFR (invasive FFR will be performed in necessary cases determined on-site by interventional cardiologists, following the recommendation of Guidelines for the diagnosis and management of chronic coronary syndromes issued by European Society of Cardiology [12])." (see Page 7, line 239-244)

Reviewer B:

I read with interest for this CT-PRECISION protocol. This randomized clinical trial aimed to compare the clinical value of guiding treatment and prognostic discrimination of CCTA + CT-MPI and CCTA + CT-FFR. The protocol described the study aim, methods, and study endpoints (both primary and secondary). As claimed by the authors, this is the first multicenter, prospective RCT to directly compare the clinical value of these two interventions. There were two published studies reported the diagnostic performance of these two strategies rather than clinical outcomes [Coenen A, 2017; Li Y, 2019]. In general, the protocol is well written, and the results of this study has potential to update current evidence on clinical value of these two strategies.

I only have one minor comment regarding the randomization method.

In the patient population section, it mentioned "competitive enrollment and random distribution methods", as well as "randomized at 1:1 ratio". However, the details of randomization were lacking. Do investigators use computer-generated numbers? Please clarify.

Reply:

Thank you for this insightful comment. We added it as your suggestion to clarify.

Changes in the text: "**Randomization procedure**

……Simple randomization shall be used in this research, aiming to achieve a 1: 1 allocation ratio. Randomization sequence shall be independently generated through software (SPSS 22.0) by a statistician who will not participate rest of the research. Random seed shall be determined according to time of sequence generation (for example, if time is 19:35:14, the random seed shall be set as 193514). Based on the random seed, a random number table ranging from 0 to 1 shall be generated and the allocation of participants shall be determined by the size of corresponding random numbers. The random seed and random number table shall remain confidential until the end of trial. Sequentially numbered, opaque, sealed envelope (SNOSE) technique shall be used to achieve allocation concealment. Randomization group will be written on paper and kept in sealed opaque envelopes labeled with serial numbers. Once the patient is consent to participate, the envelope with corresponding serial number shall be opened and the participant will be assigned according to instructions in envelope." (see Page 5, line 164-176)