Peer Review File

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Reviewer A

The authors performed a narrative review concerning the quality of the lymphadenectomy in lung cancer resection. The paper deals with an important issue and is well organized and written.

I have one comment.

The authors should mention postoperative local recurrence within the lymph node dissection area as a way to assess the quality of lymph node dissection.

We thank the reviewers for this comment. To our knowledge, there is no data specifically referring to recurrence within the lymph node dissection area as a way to assess quality of lymphadenectomy. In our experience, recurrence within the lymph node bed without any lung parenchymal recurrence is usually associated with poorly differentiated neuroendocrine and large cell malignancies.

Reviewer B

I congratulate the authors for selecting such an interesting topic. The manuscript is well written and approaching some of the most relevant questions related to the extent of lymph node dissection during lung cancer surgery. I have some comments and I thank the authors for reading and considering my suggestions.

1. Nowadays, according to the literature, segmentectomy is replacing lobectomy in early and peripheral cases of NSCLC. In daily practice the extent of lymph node dissection after segmentectomy and, of course, after wedge resection, is debatable and the object of many publications. Narrative overviews are useful educational articles presenting a broad perspective on topic under debate but, to me, this manuscript fails facilitating a synthesis of the current debate on the extent of lymphadenectomy in early-stage cases treated by lung parenchyma-saving resections.
   We thank you for this suggestion and have included an additional paragraph on lymphadenectomy during segmentectomy (lines 194-225).

2. According to my previous comment, the terms “segmentectomy” and “wedge resection” should have been included in the literature search.
   We have added this to our search and have included the data on segmentectomies and lymphadenectomy as outlined above.

3. Also, the term “mediastinal” could have been useful in the search.
   We thank you for this suggestion and included it in our search.

4. At least one table abstracting the recommendations from different international societies would have been useful from an educational point of view. Such a table could include four columns: society, year of publication, recommended lymph node stations and minimum number of nodes per station.
   We thank the reviewers for this suggestion and have now tabulated the guidelines as represented in Table 1.

5. From a formal point of view, the title “Discussion” (line 114) is not the best. I’m suggesting “Results of the search” instead. Discussion of the findings start at line 201 maybe.
   We have duly noted this suggestion and changed the manuscript to reflect as such.

Reviewer C

Systematic lymphadenectomy is conventional principle but there are several opposite concepts, for example, lobar-specific lymphadenectomy in low-malignant type lung cancer (e.g. GGN-predominant small-size nodule).
As authors cited, there are several clinical trials (ACOSOG Z0030, JCOG1413(UMIN000025530)).

Through the manuscript, authors seem to keep standing one side and supporting conventional procedure. Reviewer respects the authors’ thought, but the review article should include various type of opinion and show several different opinions even if narrative review.
In this point, the manuscript is not enough as review article.

For easy reading, table or figure should be used to summarize the studies or recommendations by each guideline instead of simple list or series description.

We thank you for this suggestion and have now tabulated the guidelines as reflected in Table 1.