

Peer review file

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Reviewer A

Comment 1: L.86: He says: “Competing risk nomogramsfor breast cancer, renal cancer and lung cancer”. Should say: “Competing risk nomogramsfor breast cancer, renal cancer and thyroid cancer”

Reply 1: Thank you for your suggestion.

Reply 1: we have modified our text as advised (see Page 4, line 20).

Comment 2: METHODS: The authors should specify in the text the grouping of the histological types.

Reply 2: Thank you for your suggestion.

Changes in the text 2: we have modified our text as advised (see Page 6, line 8-9).

Comment 3: L.219: Errata: IITMIG is incorrect; the correct acronym is ITMIG

Reply 3: Thank you for your suggestion.

Changes in the text 3: we have modified our text as advised (see Page 11, line 1).

Comment 4: L.244: It is the first time that the acronym OS is used in the text; therefore, it must be defined

Reply 4: Thank you for your suggestion.

Changes in the text 4: we have modified our text as advised (see Page 12, line 5).

Comment 5: The authors omit prognostic factors such as tumor size and immunohistochemically profile. Understandably, it is possible that this is data not available in the SEER database. However, the authors should have referred to them in the discussion and analysis of limitations of the study.

Reply 5: Thank you for your suggestion.

Changes in the text 5: we have modified our text as advised (see Page 14, line 1).

Reviewer B

This database study by Zhang, et al. is aimed to establish the predictive model for cause-specific mortality in thymoma patients. The focus of this paper is interesting and the detail competing risk analyses could represent the clinical feature of thymoma. Several limitations below should be addressed.

Comment 6: Because this study is special big-data analyses, the biostatistician who is responsible to this investigation should be listed as a co-author.

Reply 6: Thank you for your suggestion. The first author was good at statistics and he was responsible for data analysis and statistics.

Changes in the text 6: no changes were made in our text.

Comment 7: Since thymoma is low-grade malignant as the author comments, the survival outcome has been sometimes calculated using disease-specific survival, not overall survival, so far. Author should discuss the difference of clinical significance with risk competing survival analyses studied in this paper.

Reply 7: Thank you for your suggestion. Given the high incidence in the elderly as well as the relatively long-term survival for patients with thymoma, a considerable number of patients may die of other non-cancer causes. We have discussed the importance of competing risk analysis in Introduction (see Page 4, line 13-18)

Changes in the text 7 no changes were made in our text.

Comment 8: Median follow up period of 65 months is too short to analyze the thymoma cases. At least, 10 years would be required for accurate analyses in thymoma patients.

Reply 8: Thank you for your suggestion. We agree that thymoma patients could achieve long term survival and at least 10 years of follow up is necessary. However, for patients with thymoma selected from SEER database between 2004 and 2016, the median follow up was just over 5 years. If we limit the enrollment time to ensure 10 years of follow up, then the number of cases will decrease and thus influence the accuracy of nomogram. As a result, we chose patients in SEER database from 2004 to 2016 to analyze and build a competing risk nomogram.

Changes in the text 8 no changes were made in our text.

Comment 9: Stage, histology, and treatment modality are probably confounding as variables. So, this point should be resolved by biostatisticians, not clinical physicians.

Reply 9: Thank you for your suggestion. We did multivariate analysis using proportional subdistribution hazard model to account for confounding variables such as stage, histology, and treatment modality.

Changes in the text 9 no changes were made in our text.

Reviewer C

Comment 10: This manuscript is novel and well-written. The authors have made a good attempt at building a competing risk nomogram to predict cause-specific mortality for thymoma. I have one question. Page 6, line 170; I think SHR is 3.88, not 2.67.

Reply 10: Thank you for your suggestion.

Changes in the text 10we have modified our text as advised (see Page 8, line 17).