Peer Review File

Article Information: https://dx.doi.org/10.21037/jtd-22-81

Reviewer A

Comment 1: The design of the study is appropriate and given the rarity of thymic MALT lymphomas, it becomes an important source of concise information about this neoplasm. However, the manuscript cannot be accepted in its current form due to the substantial number of grammatical errors (too numerous to list here, particularly in the Discussion). It is mandatory to have this manuscript reviewed by an English native speaker.

Reply 1: Thank you for your comment! We have sought professional editing. We hope the writing is acceptable for publishing now.

Comment 2: In addition, the term "MALT" alone cannot be used as an acronym for MALT lymphoma. Therefore, in all instances the term "thymic MALT" should also include the word "lymphoma".

Reply 2: As suggested, we used "MALT" as the acronym for "mucosa-associated lymphoid tissue", and added the word "lymphoma" to the term "thymic MALT".

Changes in the text: All the acronym “MALT” in the text has been changed to "MALT lymphoma".

Comment 3: In the discussion (pg 10, lane 190) the term "Hodgkin's disease" should be changed to "Hodgkin lymphoma".

Reply 3: Revised as suggested

Changes in the text: Page 16, lane 302 (page 14, lane 262 in the file without marks).

Comment 4: On pg 10, lane 194, the authors write "To clinically differentiate thymic MALT with other thymic cystic lesions (thymic hyperplasia, thymoma and thymic cysts) is more difficult." In fact, this is virtually impossible to do clinically or by imaging and thus, a diagnosis

of thymic MALT lymphoma can only be established microscopically.

Reply 4: Here, the sentence was written to express that the image findings of thymic MALT lymphoma are hard to differentiate with other thymic cystic lesions. We are sorry about the inaccuracy. The sentence has been revised as "Other thymic neoplasms such as thymic hyperplasia, thymic cysts, and thymic epithelial tumor could be manifested as cystic lesions in image findings, which were hard to differentiate with thymic MALT lymphoma."

Changes in the text: page 16, lane 312-315 (page 14, lane 269-271 in the file without marks).

Comment 5: In this same line, the authors are missing to include crucial information for all cases. Were diagnoses established via biopsy/resection in all case reports and case series reviewed? This is most likely true and should be mentioned and emphasized.

Reply 5: Thank you very much for the advice. We have further discussed the use of biopsy and emphasized the value of surgery for diagnosis. Additionally, we have added a part named "Diagnosis" in the Results part to further claim this issue.

Change in the text: Page 16, lane 319-321; page 11-12, lane 209-214 (page 15, lane 275-277; page 11, lane 187-192 in the file without marks).

Comment 6: Likewise, it is crucial to include what was the initial clinical and imaging impression before diagnosis in all case reports and case series, which will provide additional important aspects of this rare disease.

Reply 6: We added the preoperative suspected diagnosis in the Supplement Table, and described it in the "Diagnosis" part in Results.

Change in the text: Supplement Table; page 11, lane 215-227 (page 11, lane 193-205 in the file without marks).

Reviewer B

Major comment 1: The authors concluded that extended thymectomy may be beneficial to patients. I think there were not sufficient supportive data to justify this procedure. First, the authors did not show extended thymectomy prolonged overall survival or progression free survival.

Reply to major comment 1: We are sorry for the inaccuracy of the expression and the misleading conclusion. Here, we would like to make further explanations about our conclusion and make corresponding revisions.

1) Thymectomy should be used in all stages if possible. For one reason, thymectomy could provide sufficient tissue to make definite diagnosis. For another, thymectomy was helpful to avoid tumor enlargement and compression of the surrounding tissue;

2) Regional lymph node sampling/dissection might be helpful in selected patients. It could help in assessing disease stage. Furthermore, since it is hard to make definite decision by intraoperative frozen pathology, reginal lymph node sampling is of importance for other thymic malignancy, such as thymic carcinoma.

In our original manuscript, we directly combined the two parts above together and drew the conclusion that extended thymectomy might be recommended, which was not proper. Thus, we have revised corresponding parts.

Change in the context: Page 4, line 51-54; page 17-18, line 337-348; page 20, line 409-411 (page 4, line 46-48; page 15, line 290-298; page 18, line 350-352 in the file without marks).

Major comment 2: Second, although MALT is a low-grade lymphoma, their treatment would be similar to follicular lymphoma or diffuse large B cell lymphomas if it is an advanced disease. Therefore, the main treatment for an advanced disease would be chemotherapy rather than surgical resection. Complete resection of the tumor including thymectomy for localized MALTs is agreeable.

Reply to major comment 2: Thank you very much for your professional advice. We have referred to some literatures on gastric MALT lymphoma and MALT lymphoma at other sites and further discussed the use of systemic therapy in thymic MALT lymphoma. However, for

advanced-stage disease, we assumed that thymectomy could help to make definite diagnosis and avoid tumor enlargement, making it still a preferred therapy if possible. Apart from surgery, postoperative systemic therapy should be considered in advanced-stage patients. Corresponding parts have been revised.

Change in the context: Page 17, line 328-331; page 18-19, line 363-373 (page 15, line 280-284; page 16-17, line 311-321 in the file without marks).

Minor points

1) Page 4 line 65

The authors mentioned that "But if thymic MALT patients only acted as a part of a cohort, the study would be excluded."

Why were those cases excluded totally? Those papers may contain important data. Please mention the reason to exclude them.

Reply 1): These studies focused on other diseases, such as non-Hodgkin lymphoma and cystic thymic lesions, in which thymic MALT lymphoma was only a part. In these studies, we could only obtain the number of thymic MALT lymphoma cases, but the information we had to extract was not available. Therefore, we excluded these studies. We revised it as "Studies in which thymic MALT lymphoma patients were analyzed with other diseases (such as other thymic lymphomas or cystic thymic lesions) as a whole were excluded, due to the unavailability of information specific to each case or aggregated data specific to thymic MALT lymphoma."

Change in the context: Page 5-6, line 81-85 (page 5-6, line 73-77 in the file without marks).

2) Eventful and uneventful patients

The authors used eventful patients and uneventful patients in the text. I guess eventful patients mean patients with relapse or/and death, and uneventful patients mean those with relapse or death from the context. However, I could not find the definitions of "eventful patients" and "uneventful patients" in the main document. Please provide the definition of the term in the context of this paper.

Reply 2): The definition has been added.

Change in the context: Page 7, line 117-119 (page 7, line 104-106 in the file without marks).

3) Page 9 line 161, Adjuvant therapy

I think chemotherapy similar to that for follicular lymphoma or diffuse large B cell lymphoma would be the main treatment for advanced MALT. I guess “adjuvant” may not be appropriate. Please consider this.

Reply 3): We have replaced "adjuvant therapy" with "postoperative therapy" and further discussed the use of postoperative radiation and systemic therapy.

Change in the context: Page 18-19, line 355-373 (page 16-17, line 303-321 in the file without marks).

4) Page 11 line 212 “If the tumor is invasive or VATS could not resect the whole tumor, open surgery should be transformed”

I can understand what the authors intended to say; however, the sentence needs to be modified.

Reply 4): We have sought professional editing, and the sentence has been revised as "Surgeons could use VATS to explore thorax and tumors now that VATS has been developed. Thoracotomy should be used if the tumor is invasive or if VATS is unable to remove the whole tumor." We hope the sentence is acceptable now.

Change in the context: Page 18, line 350-353 (page 16, line 300-302 in the file without marks).

Reviewer C

Comment 1: The terms eventful and uneventful were used multiple times throughout the manuscripts but there was no explanation of what these terms meant. Are they referring to mortality versus none? This requires clarification, perhaps in the Methods section

Reply 1: The definition has been added.

Change in the context: Page 7, line 117-119 (page 7, line 104-106 in the file without marks).

Comment 2: The manuscript did not briefly touched on the fact that resection were perhaps employed for diagnostic purposes rather than therapeutic. If data from the case reports and series are available, I would include this in the analysis as resection for diagnostic purposes that resulted in cure should be interpreted different than resection with intent-to-cure. This could be entered into the supplemental Table. if the data isn't available as to intent-to-diagnosed or intent-to-cure, then I would explain this in more detail within the discussion in regards to how that would affect outcomes (i.e. if resection has to be attempted for diagnosis regardless, should one make the argument for limited resection rather than radical treatments? Would there be a role for Chamberlain procedures to obtain diagnosis? How does case selection bias then play a role?)

Reply 2: In fact, most of studies focused on the pathological findings of thymic MALT lymphoma instead of their diagnosis and treatments. We have repeatedly reviewed included literatures and found that the intent of surgery was seldom described. Therefore, as suggested, we revised the discussion part about surgical treatment. The main points were as below:

1) Thymectomy should be used in all stages if possible. For one reason, thymectomy could provide sufficient tissue to make definite diagnosis. For another, thymectomy was helpful to avoid tumor enlargement and compression of the surrounding tissue;

2) Lymph node sampling/dissection might be helpful in selected patients;

There was no case in the current study being reported to receive Chamberlain procedure, whose value was still unknown, thus we did not discuss it in the manuscript.

Change in the context: Page 17, line 328-331; page 17-18, 338-348 (page 15, line 280-284; page 15-16, line 290-298 in the file without marks).

Comment 3: The authors should briefly described any studies (perhaps not include them in the analysis) that has previously addressed these MALT (limited stage) with chemotherapy alone (if resection for intent-to-cure is what was attempted). A brief discussion of chemotherapy alone for MALT in the literature is warranted.

Reply 3: In fact, only one patient received chemotherapy alone. However, this patient was reported in case series and the information in detail (including how to diagnose, chemotherapy regimen and events during follow-up) was unknown. After reviewing some literatures about therapy regimen in MALT lymphoma at other sites, chemotherapy (revised as systemic therapy) has been described and discussed more in detail.

Change in the context: Page 13, line 243-246; page 13, line 254-256; page 18-19, line 363-373 (page 12, line 218-221; page 12-13, line 226-228; page 16-17, line 311-321 in the file without marks).

Comment 4: The authors should be more specific in terms of the definition of metastases (i.e. page 9, line 176: patients with concurrent MALT in other organs). What Ann Arbor stage does this technically fall under (i.e. other organs as only lymph nodes?) or are these patients already classified as stage IV as the other organs are from below the diaphragm. This needs to be clarified prior to making the association with relapse and what I presumed to be distant metastases in line page 9, line 177.

Reply 4: Thank you for your questioning. We have added the Ann Arbor stage and replaced "other organs" with "other non-lymphoid organs". Here, we would like to make some explanations about not using Ann Arbor stage or distant metastasis directly. Some authors of previous studies pointed out that due to the indolent feature of thymic MALT lymphoma, concurrent MALT found in other non-lymphoid organs (such as lung, stomach and salivary gland) were prone to be considered as concurrent disease instead of metastasis. We hope the revision is acceptable.

Change in the context: Page 14-15, line 279-281 (page 13, line 244-246 in the file without marks).

Comment 5: There seems to be enough smaller case series that may be a forest plot would be

warranted in terms of displaying the results. This will likely need to include studies (if any) that employ only nonsurgical treatments for the early stage.

Reply 5: Thank you for your suggestions. We have added a forest plot of event rate of case series. Besides, we have added pooled proportion of several variables and reported the I-squared values in Table 3. There were two patients received nonsurgical treatments, and both of them were at stage II. These two patients were described and discussed in detail as suggested.

Change in the context: Table 3; Figure 3; page 8, line 148-149; page 13, line 254-256; page 14, line 273-274 (page 8, line 132; page 12, line 226-228; page 13, line 239-241 in the file without marks).

Reviewer D

Comment 1: At first the title is not suitable for the content of this manuscript.

The authors should check the definition of “systematic review”.

Reply 1:

Thank you very much for your question. According to PRISMA 2020 explanation, systematic review was defined as "a review that uses explicit, systematic methods to collate and synthesize findings of studies that address a clearly formulated question". To our understanding, this definition pointed out that a systematic review should have 3 parts – systematic method, synthesis of studies and an unsolved question. Our study used a systematic method proposed by Murad et al. specifically to case reports and case series (the literature was listed below). And we had a question on the characteristic, treatment and prognosis of thymic MALT lymphoma. We understand that the synthesis of studies was the most confusing part for a systematic review. We mainly used narrative synthesis. However, in the revised manuscript, we have added pooled proportion of variables in the case series using random-effects model, which has been reported in Table 3. Additionally, we have presented a forest plot of event rate of case series. The rationale was also from Murad et al.

Changed in the context: Table 3; Figure 3, page 8, line 148-149; page 14, line 273-274 (page 8, line 132; page 13, line 239-241 in the file without marks).

Murad MH, Sultan S, Haffar S, Bazerbachi F. Methodological quality and synthesis of case series and case reports. BMJ Evid Based Med, 2018; 23:60-63.

Comment 2: The authors concluded “It may benefit patients if choose extended thymectomy as the main treatment. And if the patient has concurrent MALT in other sites, adjuvant therapy should be considered”. What is the rationale? The rationale for leading this conclusion is the most important, but it is not mentioned anywhere in the content.

Reply 2: We are sorry for our inaccuracy on expression and the misleading conclusion. Here, we would like to make further explanation about our conclusion and make corresponding

revisions.

1) Thymectomy should be used in all stages if possible. For one reason, thymectomy could provide sufficient tissue to make definite diagnosis. For another, thymectomy was helpful to avoid tumor enlargement and compression of the surrounding tissue;

2) Regional lymph node sampling/dissection might be helpful in selected patients. It could help in assessing disease stage. Furthermore, since it is hard to make definite decision by intraoperative frozen pathology, reginal lymph node sampling is of importance for other thymic malignancy, such as thymic carcinoma.

Change in the context: Page 4, line 51-54; page 17-18, line 337-348; page 20, line 409-411 (page 4, line 46-48; page 15, line 290-298; page 18, line 350-352 in the file without marks).

Comment 3: Please explain the description of 0 or 1 in Tables.

Reply 3: The quality assessment of the current study based on a proposed tool by Murad et al. The tool assessed 5 parts of included articles, and each part scored 1 if the article met the criteria. We have revised our method part to explain this issue in detail.

Change in the context: Page 8, line 131-134 (page 7-8, line 116-120 in the file without marks).

Comment 4: Please define the start date of the database search, not inception.

Reply 4: Revised as suggested.

Change in the context: Page 3, line 29-32 (page 3, line 29-30 in the file without marks).

Comment 5: What do the authors want to say at Abstract, line 37-38, “Patients with MALT in other organs are likely to relapse and metastasis”?

Reply 5: We are sorry for the inaccuracy of the expression. We have revised the sentence as "Patents with advanced-stage disease were more likely to suffer events." In the main text, we have replaced "in other organs" with "in other non-lymphoid organs", indicating that these patients were classifies as Ann Arbor IV. Here, we would like to make some explanations about not using Ann Arbor stage or distant metastasis directly. Some authors of previous studies pointed out that due to the indolent feature of thymic MALT lymphoma, concurrent MALT found in other non-lymphoid organs (such as lung, stomach and salivary gland) were

prone to be considered as concurrent disease instead of metastasis.

Change in the context: Page 4, line 47-48; page 14-15, line 277-281 (page 3, line 42-43; page 13, line 243-246 in the file without marks).

Reviewer E

Comment 1: Method - The authors stated that they excluded studies if they analyzed patients with thymic MALT as a part of a cohort. However, if survival status or other information is available in individual MALT patient, the study would be very informative and the information should be included in this systematic review. I encourage the authors to consider this.

Reply 1: Thank you very much for the comments. In fact, these studies focused on other diseases, such as non-Hodgkin lymphoma and cystic thymic lesions, in which thymic MALT lymphoma was only a part. In these studies, we could only obtain the number of thymic MALT lymphoma cases, but the information we had to extract was not available. Therefore, we excluded these studies. We revised it as "Studies in which thymic MALT lymphoma patients were analyzed with other diseases (such as other thymic lymphomas or cystic thymic lesions) as a whole were excluded, due to the unavailability of information specific to each case or aggregated data specific to thymic MALT lymphoma."

Change in the context: Page 5-6, line 81-85 (page 5-6, line 73-77 in the file without marks).

Comment 2: Results - Some information may be extracted from each study that was included in this systematic review. How was the tumor staged? CT, PET, and MRI? Any biopsy prior to treatment performed? The authors should consider any other data should be extracted from the clinical viewpoints. Any intraoperative staging such as lymph node dissection performed?

Reply 2: Thank you very much for your questions and the recommended reference.

-About stage: All the tumors in the current study staged after pathologic diagnosis. Image findings could not make diagnosis for this rare disease.

-About biopsy: Biopsy was performed only in 7 cases, and only 2 of them had definite diagnosis. The relevant information has been added in the Results part.

- About lymph node dissection: Eleven patients had clear document of performing lymph node dissection, but none of them had intraoperative staging due to the difficulty of diagnosis even microscopically. However, we assumed that lymph node sampling might be helpful in assessing stage and in patients with suspected diagnosis of other thymic malignancy. This part was also

added in the Discussion part, and the recommended literature was referred.
Changes in the text: Page 11-12, line 215-218; page 17-18, line 340-348; Reference 73 (page 11, line 193-196; page 15-16, line 291-298 in the file without marks).

Comment 3: The median follow-up is 15 months and too short to discuss long-term survival outcomes. It may be very confusing to describe 5-year overall survival in the abstract. They could describe 5-year survival outcomes in the maintext, however, they are encourage the short follow-up as an important limitation.
Reply 3: We are sorry for the confusing expression. We calculated the median value of the follow-up time instead of using Kaplan-Meier method to calculate the median survival time. The median survival time was not reached, which has been revised in the manuscript.
Changes in the text: Page 14, line 259-261 (page 13, line 231-232 in the file without marks).

Comment 4: In advanced thymic MALT, they should consider and discuss any role of induction therapy for complete resection of the tumor. Please cite the following paper.
Reply 4: Thank you very much for the recommended paper. However, since the paper focused on thymic epithelial tumors rather than lymphoma, we assumed that this paper is not very proper for our manuscript. Besides, none of thymic MALT lymphoma case in the current study received induction therapy, which might be a result of the difficulty in diagnosis by biopsy. Instead, we discussed systemic therapy for advanced thymic MALT lymphoma in detail in the Discussion part and hope that it could be less confusing in choosing treatment modality.
Change in the text: Page 18-19, line 363-373 (page 16-17, line 311-321 in the file without marks).

Comment 5: Minor comments - There are several grammatical errors and mistypes.
page 7, line 114: inferior than should be inferior to.
line 209 reginal should be regional
Reply 5: We are sorry for the errors in language. We have revised the manuscript as suggested and found an English editor to review the manuscript. We hope the revised manuscript is acceptable to publish.

Changes in the text: Page 3, line 38; page 9, line 159; page 17, line 344 (page 3, line 35; page 9, line 142; page 16, line 295 in the file without marks).

Reviewer F

Comment 1: The authors said that there are no language restrictions regarding searching literature of relevant data. However, after this sentence, the review only included publications based on Chinese and English. Considering the prevalence of MALT is higher in Asian populations, other non-Chinese Asian countries should be included. Thus, the authors should restrict their research to only English papers or those with English abstracts.

Reply 1: Thank you for your suggestions. We did not set language restriction when searching in order to ensure the study inclusion was as comprehensive as possible. However, we had to exclude some studies due to our language restriction. If we restrict our research to only English papers or those with English abstracts, we will lose some Chinese cases. Thus, we did not change our search criteria. Instead, we revised our method part to further explain our searching and selecting process, and we added the mentioned problem as a limitation in the discussion part. We hope this revision was acceptable.

Changes in the text: Page 6, line 91-95; page 20, line 403-405 (page 6, line 80-84; page 18, line 344-346 in the file without marks).

Comment 2: The authors said that all cases with or without surgery were included in this study. However, I think that the diagnosis of thymic MALT is not easy using biopsy specimens. In the patients who did not undergo surgery, non-thymic MALT cases might have been included in this study objectives.

Reply 2: Thank you for your questioning. Only 2 cases were reported to be diagnosed through biopsy, and both of them had description of pathologic features and microscopic images to ensure the diagnosis. In fact, nearly all of the existing studies focused on the pathologic and molecular findings of thymic MALT lymphoma. Therefore, we tend to believe that it was less probable that we involved non-thymic MALT cases. To further described the issue on biopsy, we have added a "Diagnosis" part in the Results. We hope this revision is acceptable.

Changes in the text: Page 12, line 215-227 (page 11, line 193-205 in the file without marks).

Comment 3: The authors concluded that the extended thymectomy is a reasonable treatment

for thymic MALT. However, the proportion of patients who had extended thymectomy was 16.7%. Therefore, this retrospective study does not lead to such a conclusion.

Reply 3: We are sorry for our inaccuracy on expression and the misleading conclusion. Here, we would like to make further explanations about our conclusion and make corresponding revisions.

1) Thymectomy should be used in all stages if possible. For one reason, thymectomy could provide sufficient tissue to make definite diagnosis. For another, thymectomy was helpful to avoid tumor enlargement and compression of the surrounding tissue;

2) Regional lymph node sampling/dissection might be helpful in selected patients. It could help in assessing disease stage. Furthermore, since it is hard to make definite decision by intraoperative frozen pathology, reginal lymph node sampling is of importance for other thymic malignancy, such as thymic carcinoma.

In our original manuscript, we directly combined the two parts above together and drew the conclusion that extended thymectomy might be recommended, which was not proper. Thus, we have revised corresponding parts.

Change in the context: Page 4, line 51-54; page 17-18, line 337-348; page 20, line 409-411 (page 4, line 46-48; page 15, line 290-298; page 18, line 350-352 in the file without marks).

Comment 4: Regarding clinical characteristics, the mean value of proportions should be shown in results and tables.

Reply 4: Thank you for your suggestion! In stead of reporting mean value, we have added pooled proportion of several variables by using random-effects model and reported the I-squared values in Table 3. Besides, a forest plot of event rate of case series has been depicted in Figure 3.

Changes in the text: Table 3; Figure 3; page 14, line 273 (page 13, line 239-241 in the file without marks).

Comment 5: In line 132, “B symptom of lymphoma” is not clear. What kind of symptoms do the authors mean?

Reply 5: We added the explanation of B symptom, which was the generalized symptoms of

lymphoma, including fever, weight loss and night sweat. And to make the sentence less obscure, we have replaced "B symptom" with "symptoms".

Changes in the context: Page 10, line 186-188 (page 10, line 164-165 in the file without marks).

Comment 6: The name of ref. 60 should use the Roman alphabet.

Reply 6: Revised as suggested.

Changes in the text: Reference 60.

Comment 7: In figure 2, the number of patients at risk is needed.

Reply 7: Figure 2 described the Kaplan-Meier curves on OS and PFS of all thymic MALT lymphoma cases in case reports. We have revised Figure 2 and added comparison of Kaplan-Meier curves between limited-stage (Ann Arbor I-II) and advanced-stage (Ann Arbor III-IV). We are not quite sure about the term "patients at risk", which has been construed as "advanced-stage patients". Please correct us if we misunderstood.

Changes in the text: Figure 2; Page 13, line 244-245 (page 14-15, line 279-280).

Reviewer G

Comment 1: The surgical dissection area of Thymoma (and MALT) have uncertain area yet.

Reply 1: Thank you for your comment! In our manuscript, we concluded that extended thymectomy might be preferred. We are sorry for our inaccuracy of the expression and the misleading conclusion. Here, we would like to make further explanations about our conclusion and make corresponding revisions.

1) Thymectomy should be used in all stages if possible. For one reason, thymectomy could provide sufficient tissue to make definite diagnosis. For another, thymectomy was helpful to avoid tumor enlargement and compression of the surrounding tissue;

2) Regional lymph node sampling/dissection might be helpful in selected patients. It could help in assessing disease stage. Furthermore, since it is hard to make definite decision by intraoperative frozen pathology, reginal lymph node sampling is of importance for other thymic malignancy, such as thymic carcinoma.

In our original manuscript, we directly combined the two parts above together and drew the conclusion that extended thymectomy might be recommended, which was not proper. Thus, we have revised corresponding parts.

Change in the context: Page 4, line 51-54; page 17-18, line 337-348; page 20, line 409-411 (page 4, line 46-48; page 15, line 290-298; page 18, line 350-352 in the file without marks).

Comment 2: Median follow up period is very short therefore we cannot decide the biological aspect of MALT.

Reply 2: We are sorry for the confusing expression. We calculated the median value of the follow-up time instead of using Kaplan-Meier method to calculate the median survival time. The median survival time was not reached, which has been revised in the manuscript.

Changes in the text: Page 14, line 259-261 (page 13, line 231-232 in the file without marks).

Question 1: Do the high risk MALT (StageⅢ,Ⅳ) have more recurrence patients than low risk thymoma (Stage I,II) ?

Answer 1: Thanks for your question. High risk MALT lymphoma patients suffered more events

(including relapse, metastasis, recurrence, and death) than low risk ones. We had added this result to the Results part.

Changes in the text: Page 4, line 48; page 14, line 277-278 (page 3, line 42-43, page 13, line 243-244 in the file without marks).

Question 2: Do the high risk MALT (StageⅢ,Ⅳ) have the invasion with surrounding organ (lung, Aorta, pericardium, brachiocephalic vein etc.) ?

Answer 2: In fact, there were only 2 cases whose tumor was reported to invade surrounding organ. One was staged Ann Arbor IV. The tumor invaded chest wall and metastasized to the liver. Another did not have stage information. The patient was found an anterior mediastinal mass during heart surgery. And it was reported that the tumor invaded pericardium. According to these data, we could not compare the invasion of the tumor among different stages. But we have briefly described the invasion of the tumor in the revised manuscript.

Changes in the context: Page 16, line 309-310 (page 14, line 268-269 in the file without marks).

Question 3: Do Authors have any data subxiphoid extended thymectomy for MALT ?

I think extended thymectomy is better for MALT lymphoma.

Recently there is some reports that subxyphoid approach have advantage for extended thymectomy.

Answer 3: There was no reports about subxiphoid approach in thymic MALT lymphoma, and MALT lymphoma had different biological behavior from thymoma, we thus did not discuss this approach in our discussion part. As far as we were concerned, subxiphoid might be an option for those who was suspected to have thymic malignancy.

Question 4: Sjogren syndrome marge with MALT frequently.

Do Authors have any data which the symptom of Sjogren (or another autoimmune disease) improved?

Answer 4: Thank you for your question. We observed that the occurrence of autoimmune disease was not related to the occurrence of any events. Besides, autoimmune disease was not

associated with age, sex or tumor size. Given the negative outcomes, we hope it is acceptable that we did not add corresponding contents in our revised manuscript.