

Peer Review File

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First Round of Peer Review

Reviewer A

Comment 1: Major limitations of this study include the small numbers of patients for subgroup analysis (pN2a to pN2b) and its retrospective nature and

The limited number of patients for subgroup analyses in the pN2a and pN2b groups does not allow relevant conclusions. Thus, I would probably do without this paragraph and figures.

Reply: It is due to 2 factors - % of 3a lymph node resection (3.5%) and then rate of metastasis in 3a (8%). Despite our cohort being relatively big - 6348, the results of 3.5% times 8% times 6348 then paired with 3ALN- (thus times 2) pN2 cases, is a small number. To address this issue the cohort would have to be much bigger. Or in the future, some researchers might do a systematic review with meta-analysis and this data could be crucial and the small sample error would be minimized.

We already have a survival graph as supplementary figure as an addition to the maintext. Based on your and other reviewers' suggestion we decided to move Multivariate analysis as 2nd Supplementary Material. There is a new table 5 - multivariate analysis of the whole group after PSM (without subgroups). The paragraph and sentences in the text are small and mention the supplementary materials - we will keep it then.

Some researchers might find that data useful and it will be outside of the main text. We think everyone will be happy with that “middle ground”.

Changes in text: New Table 5 (Tables, Page 5), Old table 5 is now Supplementary material no 2.

Comment 2: It also does not involve preoperative evaluation with Positron Emission Tomography in all patients.

Reply: Unfortunately, the study period included times when PET in lung cancer was just introduced widely in Poland. We did not have any impact on that factor. The retrospective nature of our study shows “real” data in the “real” world. Indeed it creates a heterogeneous population. On the other hand, in some countries PET (sophisticated and relatively expensive diagnostics) is still not that accessible, so one may say that it represents actual settings. In our opinion, it has a minor effect on results as both groups had similar access to PET through the years.

In the future, Randomized Controlled trials or future retrospective ones (when PET is almost everywhere accessible) may solve this problem.

Changes in text: none

Comment 3: In addition, it would appear that standard management for N2 patients did not include induction chemotherapy before surgery.

Reply: We are so sorry, we forgot to mention it in the exclusion criteria. Neoadjuvant cases (thus operable cN2) were excluded from this study. According to the guidelines, IIIA cN2 patients are only eligible for surgery in case of neoadjuvant chemotherapy with good mediastinal remission. Thus, every pN2 case in our cohort was a “non-cN2” one.

Changes in text: Exclusion criteria are now updated.

Lines 156-157 Page 7.

Comment 4: The median follow-up period is missing.

Reply: We confused the terms. Median follow-up time was already provided but by mistake we described it as median survival time. Sorry for this mistake. It is correct now. Thank you for being so thorough.

Changes in text: Median follow up time is now provided.

Line 242 Page 10.

Comment 5: It remains unclear why patients had lymph node dissection of station 3a. Perhaps because the CT or PET was suspicious for lymph node involvement or was this standard of care in some thoracic surgical departments for all patients with lung cancer. This would create a significant bias in the study.

Reply: To our knowledge, there is no existing program in Poland to have 3a resection in their standard. Of course, we cannot speak on behalf of all surgeons, but we believe it is a minor issue (representing real-world data as standardization in lymphadenectomy in lung cancer is not well established). In most of the cases, there were two reasons - intraoperative findings indicating 3a enlargement/metastasis or surgeon nodal resection experience. Based on research regarding the more lymph nodes retrieved the better, some may aspire to resect as many nodal stations as possible (3a including). Although it is rare.

Changes in text new sentences about 3a retrieval rationale in Lymph Node Dissection part of Material and methods

Lines 144-148 Page 6

Reviewer B

Comment 1: Most patients usually are not removed 3A lymph nodes. What were the radiological and intraoperative findings in the group of patients whose 3A lymph nodes were resected? Please answer clearly.

Reply: We are sorry, that we missed that in the exclusion criteria. cN2 operable (neoadjuvant) cases were excluded. Therefore there were no radiological findings.

Regarding intraoperative findings, this could include any signs of lymph node enlargement like in any other lymphadenopathy (visible, palpable, etc.). In some cases, 3a nodes might have been resected without any findings (personal surgeon experience - way to resect more lymph nodes, etc) but to our knowledge this is rare. There are no established programs to resect this node routinely in Poland.

Changes in text: Exclusion criteria are now updated.

New sentences about 3a retrieval rationale in Lymph Node Dissection part of Material and

methods

Lines 144-148 page 6 and Lines 156-157 page 7

Comment 2: If you know that a patient has 3A lymph node metastasis before surgery, will the patient's treatment plan be the surgical treatment? Or will it be chemo-radiotherapy? Or is it surgery after induction therapy?

Reply: As we mentioned above induction therapy cases were excluded. We are really sorry for confusing this.

But theoretically (apart from this study), if the patient was cN2 in 3a, then he could be eligible for surgery in case of good remission in induction therapy (according to guidelines cN2-IIIA= neoadjuvant with potential surgery)

Changes in text: Exclusion criteria are now updated.

New sentences about 3a retrieval rationale in Lymph Node Dissection part of Material and methods

Lines 144-148 page 6 and Lines 156-157 page 7

Comment 3: Please show the proportion of patients with single lymph node metastasis of 3A only, with no lymph node metastasis to 2R or 4R.

Reply: Thank you for this suggestion, it is a great idea to include statistics regarding other lymph node stations to compare.

Regarding single station 3A. This data is already included in this study: N2a1 single station N2 without N1 involvement (skip metastasis); N2a2: single station N2 with N1 involvement. Usage of these Asamura et al. suggested new descriptors allowed us to analyze the impact of single station disease. Please check this data.

Changes in text:

Data regarding other lymph node stations (3a vs MLND ones) is now provided (New Table 3, Tables page 4) As part of data overlapped with Table 2, Table 2 was updated (Tables, Page 3)

Also, a short description of this data in results and discussion. (Lines 57-58 Page 3, Lines 236-239 Page 10, Lines 331-332 Page 14 and 355-356 Page 15)

Small sentence about new limitation regarding metastasis rate Lines 342-344 Page 14-15

Comment 4: It is difficult to understand the study design of this study.

Reply: Please elaborate with examples or suggestions. Without them, it is difficult to understand and the meaning of this comment. Maybe after all changes in text, it is now clear? Please let us know.

Changes in text: None

Comment 5: If there was no significant difference in survival between the 3ALN + group and the 3ALN- group, isn't it meaningless to resect 3ALN?

Reply: According to survival - not. According to metastasis rate, it might be valuable to resect them. Please compare now to the data that you asked - 3a in comparison to other stations. For

sure in case of intraoperative findings in the proximity of 3a lymph nodes resection is compulsory. Also please note that every way to increase lymph node yield is beneficial to patients according to numerous studies.

This question will be answered in the case of multi-institutional RCT.

Changes in text: None (partially answered by other changes mentioned above - e.g. New Table 3, Tables Page 4)

Comment 6: Also, how does the prognosis of patients with 3ALN lymph node metastasis compare to other patients? Please show the significance of the dissection of 3ALN in a more understandable way.

Reply: We don't understand what do you mean by "other patients". It is compared to non-metastatic and not-resected 3a. Do you have something other in mind? What variables would you use to compare? Please elaborate and we could possibly provide such data. Significance of resection is also now explained via metastasis rate in comparison to other, more standard lymph nodes (MLND) in Table 3 - the data that you asked for.

Changes in text: None (partially answered by other changes mentioned above - e.g. New Table 3, Tables Page 4)

Reviewer C

Comment 1: The authors do not mention the essence and that is the surgical technique. Because, we need to know what to do when we need to dissect station 3A. Is it via thoracotomy or VATS is the dissection done preoperatively or during the surgery for the resection of the NSCLC? In conclusion: the authors need to elaborate more as they state that the surgical technique differs statistically between both groups even after PSM.

Reply: We don't have exact data on why the surgeon resected the 3a lymph node. To our knowledge, there is no program in Poland to resect 3a routinely in every accredited institution. There are 2 major reasons for dissection. 1) intraoperative finding 2) surgeon experience - some of them might resect 3a routinely or occasionally. According to many studies increased lymph node yield increases survival so some the surgeons might simply resect 3a to increase the number of lymph nodes retrieved.

Preoperative evaluation of this lymph node is not included in our study as neoadjuvant cases were excluded (cN2-IIIa are eligible for induction therapy and possibly for surgery in case of good remission). We forgot to mention in exclusion criteria - it is now provided.

VATS resection of 3a is possible and doable. There is no need for conversion. In our database, any VATS conversion to thoracotomy is counted as thoracotomy. So the data regarding VATS vs Thoracotomy in 3ALN+/- is adequate. The technique itself is simple resection as in other lymph node resection in lymphadenectomy of lung cancer - taking into consideration anatomical boundaries (SVC, phrenic nerve, etc.)

Changes in text: Exclusion criteria are now updated.

New sentences about 3a retrieval rationale and technique in Lymph Node Dissection part of Material and methods.

New sentence about how conversions were counted (Material and methods).

Lines 124-125 Page 5, Lines 144-148 page 6, and Lines 156-157 page 7.

Comment 2: What are the complications of surgery?

Reply: Did you mean 3a resection or surgery at all? Complications of 3a resection include injury to adjacent structures: Superior Vena Cava and phrenic nerve. We already mentioned it in the the Introduction. Sadly we do not have data regarding such detailed complications in our database. Indirectly we might say that major bleedings from SVC were not a major issue as we do not see any impact of this on the survivals.

Changes in text: none

Comment 3. Lastly, the authors need to rephrase "liability of the circulatory system".

Reply: We are sorry for that phrase. It is a "false friend" from Polish. Our language editor rephrased all of them in the text but forgot about this one.

Changes in text: This term is now rephrased as "heart failure" thorough the text.

Line 258 Page 11 and Table 1 Page 1 of Tables.

Reviewer D

Comment 1: This study seems to be focused on occult nodal metastasis in station 3A. By definition, occult nodal metastasis is pathologic involvement of lymph nodes despite thorough and diligent clinical evaluation of regional lymph nodes. However, this study did not provide any information about nodal status before treatment such as a result of CT, PET-CT, as well as invasive mediastinal study. I suggest you include this information including any measurement about station 3A

Reply: Due to fact that the study included a period of implementation of PET-CT in Poland we decided that clinical data, especially cN stages are not reliable. Also, cN2 cases (thus IIIA) eligible for induction therapy and then in case of good remission were excluded (we forgot to mention it - it is now provided in exclusion criteria). Therefore there are no cN2 cases in the study. Thus preoperative cN2 in 3a was not included for sure. So we included only cases without preoperative findings in N2 nodes.

Changes in text: Exclusion criteria are now updated

Lines 156-157 page 7.

Comment 2: What determines whether to excise 3A is depending on the clinical variables of patient and tumor. However, this information is missing from this study. Can you provide clinical variables to the manuscript?

Reply: As mentioned above clinical factors did not have any impact on the decision. cN in times of PET implementation is not reliable, and we did not include it. Other clinical factors are of lesser importance in this study, thus we also omitted them.

This is mainly a pathological-surgical database. Only operable cases are included in the database. And we excluded neoadjuvant cases - no cN2 in this population.

We don't have exact data on why the surgeon resected the 3a lymph node. To our knowledge, there is no program in Poland to resect 3a routinely in every accredited institution. There are 2 major reasons for dissection. 1) intraoperative finding 2) surgeon experience - some of them might resect 3a routinely or occasionally. According to many studies increased lymph node yield increases survival so some the surgeons might simply resect 3a to increase the number of lymph nodes retrieved.

Changes in text: Exclusion criteria are now updated.

New sentences about 3a retrieval rationale and technique in Lymph Node Dissection part of Material and methods.

Lines 144-148 page 6 and Lines 156-157 page 7.

Comment 3: In addition to question, matching variables must be clinical variables because it defines intraoperative nodal assessment. Is there any reason that you selected pathologic variables as matching variables? Because the TNM classification is most powerful factors for prognosis, it may affect the potential prognostic relevance of station 3A by neutralizing after the author performing matching analysis by stratification by pathologic nodal status. I suggest you another matching analysis by clinical variables.

Reply: As mentioned above - not reliable cN. And most of the surgeon decisions were made intraoperatively.

Changes in text: Exclusion criteria are now updated.

New sentences about 3a retrieval rationale and technique in Lymph Node Dissection part of Material and methods.

Lines 144-148 page 6 and Lines 156-157 page 7

Reviewer E

Comment: The revised paper has many limitations, as you point out in the discussion. For example, the low rate of 3A resected may suggest that this was only performed when there was high suspicion of infiltration. At the same time, the multiple subgroup analysis makes it difficult to understand and mixes metastatic and non-metastatic as well as multiple, single, and skip lymph node metastasis. This all means that the results may not be reliable.

Reply: Thank you very much for this review. We are unfortunately aware of many of the limitations of our work that you mentioned. We agree that the nodes were retrieved when they were suspicious (intraoperative findings indicating 3a enlargement/metastasis) or because of the surgeon's past experience and their aspiration to resect more lymph nodes (more nodes = better survival according to many studies) - we described it in methods now.

We already have a survival graph in subgroups as supplementary figure as an addition to studying. Based on your and other reviewers' suggestion we decided to move Multivariate analysis as 2nd Supplementary Material. There is a new table 5 - multivariate analysis of the whole group after PSM (without subgroups). The paragraph and sentences in the text are small and mention the supplementary materials - we will keep it then. We believe it is now more reliable - based on main findings.

Changes in text: New Table 5 (Tables, page 6), Old table 5 is now Supplementary material no 2.

New sentences about 3a retrieval rationale in Lymph Node Dissection part of Material and methods

Lines 144-148 page 6.

Reviewer F

Comment 1: It is thought that there is no data because it is a registry, but is there a reason for the group that did 3A station resection in the first place?

Reply : We don't have exact data why the surgeon resected the 3a lymph node. To our knowledge, there is no program in Poland to resect 3a routinely in every accredited institution. There are 2 major reasons for dissection. 1) intraoperative finding 2) surgeon experience - some of them might resect 3a routinely or occasionally. According to many studies increased lymph node yield increases survival so some the surgeons might simply resect 3a to increase the number of lymph nodes retrieved.

Changes in text: New sentences about 3a retrieval rationale in Lymph Node Dissection part of Material and methods.

Lines 144-148 page 6

Comment 2: Is there any difference in the year of the surgery, percentage of PET CT performed, specific center or country between 3ALN+ and 3ALN-?

Reply: Regarding country: it is a national Polish database - so 1 country. Regarding center - all centers participating in the database are accredited by the Polish Group for Study of Lung Cancer and the Club of Polish Thoracic Surgeons. We provided additional data regarding mediastinoscopy (Table 1). Unfortunately, we are not able to provide more data than you asked, as we would have to prepare another dataset and perform all analysis from the start, which is impossible for us. Based on our experience we deducted that these variables are not that impactful (years, center/country). Regarding PET -CT we only have "roughly" data, as PET data collection have begun once PET was more accessible in Poland. We, therefore, decided that PET data is unreliable in this dataset (thus cN staging also) therefore we decide not to include it (it would be confusing).

Changes in text: Table 1 (page 2 in Tables) updated with mediastinoscopy.

Comment 3: What is the "iliability of the circulatory system, the variable you used?

Reply: We are sorry for that phrase. It is a "false friend" from Polish. Our language editor rephrased all of them in the text but forgot about this one.

Changes in text: This term is now rephrased as "heart failure" thorough the text.

Line 258 Page 11 and Table 1 Page 1 of Tables.

Comment 4: For the figure 2, the legends beside the number at risk table should be rewritten to improve the readability. Due to long variable name the graph looks ugly.

Reply: thank you for this aesthetic suggestion. We shortened the variable's names.

Changes in text: Figure 2 is now updated.

Comment 5: Also, as you mentioned in the limitation part, the K-M analysis lacks statistical power for the number at risk 30 or less. At least, from N1b group and after, the K-M graph is meaningless.

Reply: That's why it is only a supplementary figure. It is not included in the main body of the article. Someone might use this data e.g. for future metanalysis. That's why we decided to keep it. The paragraph is very very small, and the figure is included as a Supplementary Figure, not a regular one - so it will be published outside of the main text. It is just a small

additional thing to represent with our main findings.

We also decided to replace Table 5 - Multivariate analysis in subgroups is now as a supplementary table. New Table 5 includes only a Multivariate analysis of the entire cohort after PSM. We think it is more meaningful now.

Changes in text: New Table 5 (page 6 in tables), Old table 5 is now Supplementary material no 2.

Comment 5: Other paper described that the percentage of 3A LN metastasis is next to the 4R. And you used this finding as one of the rationale for clinical significance of the 3A LN dissection. Did you analyse the 4R station in this study? I think to use that finding as your rationale, you need to add that analysis.

Reply: A table regarding lymph node comparison is now included. Thank you for this suggestion. Also, we described it further in the text (Discussion and results).

Changes in text: Data regarding other lymph node stations (3a vs MLND ones) is now provided (New Table 3, Tables page 4) As part of data overlapped with Table 2, Table 2 was updated (Tables, Page 3)

Also, a short description of this data in results and discussion. (Lines 57-58 Page 3, Lines 236-239 Page 10, Lines 331-332 Page 14 and 355-356 Page 15)

Small sentence about new limitation regarding metastasis rate Lines 342-344 Page 14-15

Comment 6: Are there any data of the LN size in your registry? It seems that , as you wrote in the "preoperative staging and follow up" section, CT scan measured the size of the lymph nodes. Are there any data for 3A LNs? If so, it can be added for more details.

Reply: We forgot to mention it (it is now mentioned in revised version) that neoadjuvant/induction therapy cases were excluded (thus cN2-IIIA is not included). Therefore any preoperative finding regarding metastatic cN2-3a lymph node would be excluded. We do not have data regarding the exact size of the node, but we are sure that there was no indication of metastasis in this node preoperatively.

Changes in text: Exclusion criteria are now updated.

Lines 156-157 Page 7.

Second Round of Peer Review

Reviewer A

General Note: This study has strength in that it used a multicenter database and raised concern about the incidence of metastasis to station 3A. The author tried to minimize unmeasured bias through propensity score matching analysis in their work. However, the statistical methods were not sound in selecting matching variables and the additional analysis (Cox PH) after propensity score matching. This resulted in another selection bias. As a result, the author's hypothesis was not well studied, and the author's conclusion could not be generalized nor fit to a specific population because the population of the study cohort was not well-defined. Although

the author revised the manuscript, it needs additional major revision.

General Reply: Thank you for your thorough review. Selecting variables both in PSM and Cox models is not something obvious as it seems. After many papers and works and discussions with statisticians we learned that models are as equal. One researcher or reviewer prefers a-priori selection of variables that are clinically important, others prefer backward selection. We believe it is matter of opinion and personal choice rather than significant bias.

Please note, that our similar article (with very same methodology but with left-sided cancer population) about other side of lung cancer and 4L lymph nodes is already published in prestigious European Journal of Cardio-Thoracic Surgery. Thus, we believe our methodology is sufficient.

Gryszko GM, Cackowski MM, Zbytniewski M, et al. The impact of left lower paratracheal (4L) lymph node dissection on survival in patients with surgically treated left-sided NSCLC. *Eur J Cardiothorac Surg.* 2021;60(5):1201-1209. doi:10.1093/ejcts/ezab294

Major comments:

Comment 1. The authors stated that patterns of failure were assessed, and cancer recurrence was classified into two categories in the preoperative staging and follow-up section in the Methods. However, there were no results related to them. It is worth adding recurrence patterns in relation to 3A dissection in the results and discussion.

Reply: We wanted to provide additional variables (eg. RFS or CSS) Sadly due to incompleteness of our database we are unable to provide it. Apparently not all institutions and clerks provide sufficient data regarding this matter. As in IALSC standards we only include patients with full data of variables we analyze. If we wanted to provide data for this variables, our study population would be smaller 10-fold. Therefore our statistical power would be even lower or even not-existing. In future we must address this issue with our database. Nevertheless, 5 year Overall Survival is the most important oncological variable and we provided it.

Changes in text: Unfortunately none.

Comment 2. It is still uncertain what the study cohort represents because they revealed that the cN stage is unreliable and did not provide any clinical stage. Even, mediastinoscopy has been done only 11-12% of the patients. As the clinical staging is the most important determinant of therapeutic decision as well as of surgical practice, the author's work has significant limitations to apply in clinical decision-making.

Reply: cN data is now provided. cN stage did not differ significantly between subgroups both pre and post PSM. In multivariate analysis cN failed to be independent prognostic factor.

Changes in text: cN is now provided in Table 1 and Table 5 (file Tables, page 2 and page 6)

Comment 3. The author should clarify which way the resection of the 3A lymph nodes benefits in the advanced stage, as stated in the conclusion of the Abstract. There was no difference between the unmatched 3a resected group and 3a non-resected group. Consistently, after PSM, there still seemed to be no difference between them. Increased incidence in the advanced T stage does not tell the benefit of resection because resection of 3a did not increase the risk of death in the multivariable analysis after PSM.

Reply: It is based on metastasis rate. Also compared to other routine stations the metastasis are

more frequent

Also, 3A metastasis rate is higher overall than other routine MLND stations: 2R, 7, 8, 9. This is even more apparent in upper lobe cases (Table 3)

Per analogy to your comment: Should we waive importance of stations 2R, 7, 8, 9 as they are less metastatic than 3A?

One single station might not be that significant (statistically wise) but as part of entire lymphadenectomy method it might.

We know that it was not confirmed in multivariable analysis. That's why we suggest it is more of possibility of significance. Its impact may be complex. One hypothesis include: higher yield of lymph nodes. Obviously 1 lymph node more might not be enough, but with other additional lymph nodes it might increase the survival (as in Ludwig et al. work where up to 16 lymph nodes increased the survival). Other include micrometastasis, which have better survival than regular metastasis and sometimes is not detected during regular pathology. This of course would be addressed in future RCT. In future, we aim to perform a RCT based on this study as a pilot. With better study power and higher population it might become impactful on survival.

Changes in text: None. Most important rationale (metastasis rate depending on pT, and metastasis rate in comparison to other lymph node stations is already provided)

Minor comments:

Comment 4: Consider changing every word "percentage" to "incidence" for better readability.

Reply: Thank you. It is indeed better phrase. We changed it.

Changes in text: Word 'percentage' was changed to word 'incidence' thorough the entire manuscript (Numerous changes thorough entire manuscript)

Comment 5: It would be better to limit the x-axis (Time in years) of Figure 2 to 5 years because there was a lot of censoring after 6 years in the author's cohort.

Reply: Thank you for this suggestion .We limited the x axis of figure2.

Changes in text: Figure 2 is changed.

Reviewer B

Comment: The revision had improved the quality of study a lot. However, the dissection of 3A LN was not done routinely or under any principles, the clinical significance of this study is very limited. At present, it can only suggest the possibility of the "significance of the 3A LN".

Reply: Thank you! We also believe our manuscript is much improved. Despite limited clinical significance we believe this is important study that could pilot to important Randomized Controlled Trial about this lymph node station. Such study would answer directly "the possibility of significance".

Third Round of Peer Review

Reviewer A

Comment: The authors responded well to the reviewer's request. They intended to raise a concern about the relatively high incidence of station 3A metastasis in the study cohort, postulating the possible significance of 3A dissection. However, due to the limitations of the study cohort, this study could add no further useful information in addition to the current

literature. Moreover, clear discussions about the results were still deficient in the manuscript. For example, the 3ALN+ group showed better survival in pN0 compared with 3ALN- group (although there are no significant differences). This might be explained by undiscovered 3A metastasis in the 3AL- group, and thus, this group might not have a chance to undergo beneficial adjuvant therapy. Likewise, the authors should have reflected the suggestions from the reviewers on the revised manuscript, but failed to do it. The authors need to interpret the results based on potential residual disease (i.e., “uncertain resection”) and the possible role of removal of micrometastatic disease, not only listing the results comparing similarities and dissimilarities with others’ works. I believe this must improve the quality and significance of their study.

Reply: Thank you for this suggestions. We provided additional explanation in discussion regarding your comment about discussion part.

Regarding “not reflecting suggestions from reviewers”: Please note that out of 31 reviewers comments we provided additional data or text in case of 23 comments since first submission of this manuscript. Half (4) out of 8 comments without changes in text are explained as limitation of our study or in discussion. We now provided additional sentence about lacking variables that we cannot provide in limitations of the study. Other “not-reflected” comments are either confusing or ambiguous, and reviewers did not clarify them at our requests (There were 6 reviewers in first round of reviews, now only 2).

This is also confusing because you noted that we responded well to the comments and then you say that we do not reflected on them? These statements are ambiguous.

Changes in text: New paragraph in discussion: Lines 343-355 (Page 14/15) with 2 additional references (no 21 and 22) – Lines 459-462 Page 20.

New sentence in limitations of discussion: Lines 371-373, page 16.

Reviewer B

Comment: The revision had improved the quality of study a lot. However, the dissection of 3A LN was not done routinely or under any principles, the clinical significance of this study is very limited. At present, it can only suggest the possibility of the "significance of the 3A LN".

Reply: Thank you! We also believe our manuscript is much improved. Despite limited clinical significance we believe this is important study that could pilot to important Randomized Controlled Trial about this lymph node station. Such study would answer directly “the possibility of significance”.