

Peer Review File

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Reviewer A

We sincerely thank the reviewer for your time and insightful comments, which have undoubtedly improved the quality of our manuscript.

Comment 1: Study design flaws, specifically questioning whether CT scans were offered to patients who then opted not to follow up, or if CT scans were not initially offered. Clarifying this aspect is crucial for a comprehensive understanding of the study's findings and implications.

Reply 1/Changes in the text: This clarification has been added upon the recommendation of the reviewer. Line 279-283

Comment 2: How many of the patients included in each cohort received guideline concordant treatment for their disease. If the treatment did not adhere to the guidelines, then the FU might also deviate. This creates bias in the interpretation of the findings of the study.

Reply 2/Changes in the text: Our study on the impact of radiological follow-up does not address the assessment of whether the treatment received by each patient was the optimal treatment according to the guidelines in force at that time. The GEVATS group, to which this study belongs, has already analyzed the treatment received with the data from this database, such as the type of resection.

1. Embun R, Royo-Crespo I, Recuero Díaz JL, et al. Spanish Video-Assisted Thoracic Surgery Group: Method, Auditing, and Initial Results From a National Prospective Cohort of Patients Receiving Anatomical Lung Resections. *Arch Bronconeumol.* 2020;56(11):718-724. doi:10.1016/j.arbr.2020.01.009
2. Sesma J, Bolufer S, García-Valentín A, et al. Thoracoscopic segmentectomy versus lobectomy: A propensity score-matched analysis. *JTCVS Open.* 2022;9:268-278. Published 2022 Jan 22. doi:10.1016/j.xjon.2022.01.009

Comment 3: The surgical margins are missing from the variables that were examined in this paper and it is crucial to be included.

Reply 3/Changes in the text: Surgical margins were not recorded in the database as all patients included in the study were, by definition, R0 resections.

Patients with R1 resections had been previously excluded as presented in *Figure 1*.

Comment 4: Can the authors explain why the patients in both cohorts had similar T and N stages but the rates of adjuvant treatment were so dramatically different?

Reply 4/Changes in the text: As observed in **Table 1**, patients from both cohorts did present significant differences regarding STAGE, hence the differences regarding having received adjuvant treatment.

Comment 5. The authors are advised to elaborate further in the introduction section about the existing guidelines on follow up CTs after surgical lung resection for NSCLC.

Reply 5/Changes in the text: Following the reviewer's advice, a more elaborate introduction has been made on the existing guidelines for follow-up with computed tomography after surgical resection of lung cancer.

(Lines 210-244)

Reviewer B

We sincerely thank you for your time and your useful comments, which have undoubtedly improved the quality of our manuscript.

Comment 1. Introduction

Further justifying the focus specifically on radiological surveillance and its distinct optimization from other components of follow-up care would sharpen the research question. Expanding on surveillance literature beyond lung cancer (e.g., breast cancer) can frame the study in a broader context of personalized care paradigms for cancer survivors.

Reply 1/Changes in the text:

The introduction and the specific focus of radiological surveillance have been expanded following the suggestions of reviewers A and B. An enhanced contextualization of the study has been added to the introduction, as suggested by reviewer B, expanding the relevance of personalized follow-up not only to patients with lung cancer but to all cancer patients.

(Lines 210-244)

Comment 2: Methods

The authors may consider conducting additional sensitivity analyses around loss to

follow-up. Elaborating on the rationale behind low-frequency and high-frequency group definitions could aid reproducibility and application. Were clinical guidelines considered in determining cutoff thresholds?

Reply 2/Changes in the text:

The text has been supplemented with the required justification following the definition of low and high frequency groups and their clinical justification with the current literature.

(line 293-302)

Comment 3: Results

- Inclusion of supplemental visual abstracts or infographics highlighting key results may enhance accessibility for diverse readership.

Reply 3/Changes in the text:

Thank you for your recommendation. Should the editors of the JTD journal deem it appropriate, a new figure will be attached per the reviewer's suggestion, in the form of an infographic styled as a visual abstract, highlighting the key results of the study.

Comment 4:

Discussion

- Comparisons and contrasts to related studies could be expanded to situate new findings in the wider evidence landscape. How do results align or divert from postoperative surveillance guidelines?

Reply 4/Changes in the text:

The comparison of the findings from our study with other recent studies has been expanded.

(Line 389-398)

Comment 5: Discussion

- Comparing the cohort characteristics and healthcare system contexts to other related studies could identify generalizable and setting-specific aspects.

Reply 5/Changes in the text:

The discussion has been supplemented with the specific context of the Spanish health system, characterized by universal healthcare coverage and where lung cancer follow-up is conducted by various healthcare professionals. (Line 279-283 and 427-432).

Comment 6:

- Projecting recommendations for risk-criteria and frequencies for tiered guideline development could start translation into clinical practice.

Reply 6/Changes in the text: The authors contend that the data obtained and reflected

in our study do not constitute sufficient evidence to warrant modifications of criteria and follow-up frequencies in current guidelines. We consider our study an initial seed for the future development of the hypothesis on the benefit of personalized oncological follow-up.

Comment 7:

- Drawing links between the need for personalized radiologic surveillance and larger movements toward individualized care in oncology care emphasizes its alignment with larger practice shifts.

Reply 7/Changes in the text:

This clarification has been added upon the recommendation of both reviewers. Line 210-222

Reviewer C

This is a good review from the database. However, the conclusion the authors have reached does not signify any learning point nor will change treatment guidelines. The patients who were on adjuvant treatment or squamous cell carcinoma has a different disease progression as compared to the early lung cancer patients who had surgery alone as a modality of treatment. The natural history of the disease is completely different in both and the oncologists will follow them as per protocol. TO get an additional radiological investigation is a burden on the healthcare system and also for the patient with no survival benefit.

We appreciate the time dedicated to reviewing our study. The authors do not seek to establish a change in the radiological follow-up protocols for patients with lung cancer with the data obtained, but rather to advance the goal of individualization and personalization of oncological follow-up for cancer patients.