Peer Review File

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Reviewer Comments

Comment 1: When there are so many ICIs available, would be important to focus a bit more on why tislelizumab compared to pembro? Pembro's pCR rates seem to be superior although we cannot do a comparison due to the lack of a head-to-head trial. You also do point out that this study had more stage III than KEYNOTE 522. Is Pembro not easily available in the global context? Is this less expensive than other ICIs? The unique mechanism of action compared to other ICIs that may make tislelizumab more effective? This viewpoint needs to be brought out a bit more clearly. The point about a better chemotherapy partner and fewer cycles is noted and an excellent one at that.

Reply 1: Thank you for your valuable review and comments. Mainly to keep the opinion short/word count limit, these points were not elaborated, now it is revised in track mode.

a) KEYNOTE-522 was the landmark study with breakthrough results and pembrolizumab obtained FDA approval for TNBC.

b) Pembrolizumab is the same class of drug as tislelizumab for comparisons and exhibited a superior pCR rates in KEYNOTE-522. While atezolizumab was also approved, its efficacy varied in the surrogate endpoint -pCR. KEYNOTE-522/ Pembrolizumab is not only a good choice for comparisons but also to gain lessons to improve the domestic drug development for TNBC.

c) There is no comment on the availability of pembrolizumab in the global market in this editorial. However, we want to derive the point that, encouraging domestic drug development would make the nation self-reliant and make the therapeutics affordable (cost-effective) while also meeting the growing demand. (Aforementioned points are added/revised in the line numbers: 47, 95, 101-104, 118-122, 158-161, 170)

d) Yes, tislelizumab has a unique structural advantage over other anti-PD-L1 antibodies. Revised in line numbers: 50-61, 104-107)

Comment 2: If feasible, would be great for the author to comment on the global implications of tislelizumab and whether they envision this coming to the global market for TNBC. Why or why not?

Reply 2: Thank you for this suggestion. Tislelizumab has no development plan on the TNBC indication registry at the global level as the phase 2 results are not mature yet and only confirmatory clinical data from phase 3 could provide direction on its implications at both local and global levels.

Comment 3: Line 66-68 needs a reference

Reply 3: Added reference, thank you.

Comment 4: Line 76 – please clarify what is meant by "radical" surgery – did the author mean mastectomy or breast-conserving surgery or simply definitive surgery?
Reply 4: Thank you for pointing out this. Yes, it is definitive surgery.

Comment 5: While talking about the adverse effect profile of tislelizumab, would be good for the author to comment on whether this is comparable to other ICIs rather than commenting on how each ICI is compared with immunotherapy.
Reply 5: Thank you for your suggestion. Since there are no head-to-head clinical trials, comparison of adverse events becomes difficult. However, AE is revised/compared as per your suggestion. Line number 137-142.