Peer Review File
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Reviewer A:

Comment: I thank the editor for the opportunity to review this interesting paper. I have only few consideration for the authors. The inclusion of EUS-B procedures should be surely mentioned but I think that is a procedure that is performed when it is not available the EUS, therefore it can not be considered as a standard. Please, analyze the outcomes of EUS and EBUS on station 7, some paper indicated that EUS-FNA has a better sensitivity on this station compared to EBUS (Assisi D, Gallina FT, Forcella D, Tajè R, Melis E, Visca P, Pierconti F, Venti E, Facciolo F. Transesophageal Endoscopic Ultrasound Fine Needle Biopsy for the Diagnosis of Mediastinal Masses: A Retrospective Real-World Analysis. J Clin Med. 2022 Sep 17;11(18):5469. ) Please cite this article.

Reply: Thank you for the comment, Reviewer A. We have read through the included article and did not see a direct comparison of outcomes between EUS and EBUS. However, we did include this citation in Section III under “mediastinal lymph nodes” (lines 168-170 on the previously reviewed draft). There is a comparison of EBUS to EUS at stations 5, 6, and 7 that is included in the same section.

Reviewer B:

This review summarizes the significance of adding EUS-FNA or EUS-B-FNA to EBUS-TBNA in staging of non-small cell lung cancer. It also systematically mentions the differences between EUS-FNA and EUS-B-FNA, which will be easy for readers to understand. The following items need to be confirmed and minor corrections made, but are deemed to be essentially acceptable for publication.

Thank you for the feedback, Reviewer B. Our responses are below with the appropriate edits made in the paper.

Major comments

Comment 1. The advantages of the EUS scope over the EBUS scope are described in lines 108–114, but the greatest limitation of the former is its larger diameter, which should be added in parallel and mention that it is not inserted transbronchially. In fact, there is also described the advantage of the smaller diameter of the EBUS scope in lines 138–140, which is important as a difference between the two scopes.
Reply 1: The differences in scope diameter have been emphasized in this section.

Comment 2. In lines 155–163: The accessible stations are listed from the citation #38, but the paper does not include #2R/2L, which needs to be removed. In addition, Table 1 should summarize lesion accessibility by EBUS and EUS scopes (as it includes lesions other than lymph node, the title should be corrected), but it is not consistent with the description in the text (e.g., left adrenal gland is accessible by EBUS scope, even though it is located below the diaphragm). Accessibility depends on the localization of the lesion as well as the distance from the central airway or esophagus to the lesion. It is difficult to make a clear distinction between accessible or inaccessible, since accessibility to #1, #3a, etc. depends on the latter condition (note that #1 is incorrect for "higher mediastinal" and should be listed as "supraclavicular" according to the IASLC lymph node map. It is strongly suggested that they are divided into three groups, such as accessible, may accessible, inaccessible, etc., and re-stated.
Reply 2: Thank you for the remarks. The appropriate edits have been made to Table 1.

Comment 3. In lines 231–232: The context doesn't fit, but are you intending a comparison between EUS and EUS-B? It also should be confirmed that the citation is correct, as the contents do not

match the citation #58.
Reply 3: The sentence has been removed and the correct information correlating with the citation has been included.

Comment 4. In lines 324–330: The decision on whether or not to add mediastinoscopy in the case of negative EBUS/EUS has been somewhat divided among the guidelines. However, based on the results of the recent RCT (J Clin Oncol. 2023;41(22):3805–3815. doi: 10.1200/JCO.22.01728.), it is highly likely that the trend will flow toward omitting it in the future. This is an important finding and should be included in the citation and the description adjusted.
Reply 4: Thank you for the citation of the recent publication. We have added this study to our review article.

Comment 5. The submission file contains three figures, but there is no mention of the relevant section in the text and no legends are found. If necessary, please make them presentable.
Reply 5: The three figures have been rearranged and references added to the body text. Legends have been added to the figure descriptions.

Minor comments
Thank you for your comments, the appropriate changes have been made in text.

Comment 6. The "et al." are sometimes with a period and sometimes without, sometimes in italics and sometimes not. Its description should be unified.
Reply 6: “et al.” has been changed throughout the paper to include the period and to be without italics.

Comment 7. In lines 289–290: described? reported?
Reply 7: the duplicate word has been changed to “reported”.

Comment 8. In line 293: duplicate article “a"
Reply 8: the duplicate word has been changed.

Comment 9. In line 334: cannot always be biopsied?
Reply 9: the phrasing has been changed.

Comment 10. In the Limitations, "EUS-B FNA" and "EUS FNA" are mentioned, but the hyphen should be placed before the FNA.
Reply 10: the hyphens have been added

Reviewer C:

Comment 1. The authors give an excellent and informative description of current techniques for transbronchial and transesophageal sampling of intrathoracic/subdiaphragmatic lesions and lymph nodes. EBUS-TBNA, EUS-BFNA, and EUS FNA are well described. While in the procedure's technique field, it would be very interesting to expand the information about the features of the different types of needles, particularly the length of the EUS and EBUS needles, and how that affects the possibilities of sampling the lesions.
Reply 1: We have included information regarding the differences in the needles used with EBUS and EUS.

Comment 2. It would be interesting to see the raw data of the case series of those 20 patients. (row 236)
Reply 2: We have added the citation for the case series.

Comment 3. Could the authors consider referring to newer studies on occult metastasis in

radiologically normal mediastinum? (row 270-274)
Reply 3: The studies in this section looked at occult metastases that were detected by EUS specifically. Unfortunately, there was a lack of newer studies looking at occult metastases detected by EUS specifically in normal mediastinum. We have included what was available and applicable to this section of the paper. There are however, more recent studies that describe using EBUS to detect occult disease which were not included in this review article.