Supplementary

Appendix 1

Response to "The critical role of PD-L1 expression in immunotherapy for advanced non-small cell lung cancer"

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Response to: Deng Y, Li Y, Xu R, Li J, Cui W. The critical role of PD-L1 expression in immunotherapy for advanced non-small cell lung cancer. Quant Imaging Med Surg 2025. doi: 10.21037/qims-2025-209.

We appreciate the comments on our manuscript from the readers (1), entitled "*Maintenance treatment of immunotherapy after microwave ablation plus drug-eluting bead bronchial arterial chemoembolization for advanced non-small cell lung cancer*: *a retrospective single-center cohort study*" (2). Some essential explanations and corrigenda in the comments were listed as follows.

This retrospective study is a preliminary study to attempt the therapeutic pattern of the combination of immunotherapy and multiple interventional techniques in advanced non-small cell lung cancer (NSCLC), and has included patients who are resistant or intolerant to standard treatments, which might contribute to the potential heterogeneity of patient selection. We have listed it as one of the limitations.

In this study (2), the programmed cell death protein 1 (PD-1) blockade was administered to advanced NSCLC patients who had programmed cell death-ligand 1 (PD-L1) tumor proportion score (TPS) ≥10%. Group A of this study enrolled advanced NSCLC patients with PD-L1 TPS of 10–49%, which was confirmed by the previous biopsy. In theory, chemo-immunotherapy should be performed for those patients, as recommended by guidelines, and mono-immunotherapy was usually considered for advanced NSCLC with PD-L1 TPS ≥50% (3). As we have mentioned in this study (2), drug-eluting beads with bronchial artery chemoembolization have been investigated as a salvage or replacement therapy for patients with advanced NSCLC who are resistant or intolerant to systemic chemotherapy (4-7), which was determined by the multidisciplinary treatment team of our institution.

Moreover, we acknowledge that PD-L1 expression is a biomarker to predict the prognosis of perioperative immunotherapy in resectable NSCLC, and we think that it might be a predictor of prognosis for immunotherapy plus interventional therapy. However, the limited sample size of patients who received immunotherapy and the lack of groups with PD-L1 TPS of 0–1%, 1–10%, and ≥50% prevented the further investigation. As for the other two groups, some patients had not undergone the PD-L1 expression test, while some patients presented with PD-L1 TPS of 0–10%, which contributed to the incomplete data of PD-L1 expression for all of the patients. Therefore, studies with larger sample sizes and different groups of PD-L1 expression were warranted in the future.

Moreover, we regret to find the mistakes in the number of patients under the indications for interventional therapy in *Tab. 1* of the published manuscript (2). We have reviewed the related data again and found that the false calculation existed and the numbers need to be corrected. The P value of the corrected data between the three groups was 0.508, which still showed no significant difference and had

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Table S1 Corrigenda of "Clinical characteristics for patients with advanced NSCLC in the three groups"

Variables	Overall (n=95)	Group A (n=15)	Group B (n=25)	Group C (n=55)	P value
Indications of interventional therapy					0.50
Resistance to standard treatments	57 (60.0)	7 (46.7)	16 (64.0)	34 (61.8)	
Intolerant to standard treatments	38 (40.0)	8 (53.3)	9 (36.0)	21 (38.2)	

Frequencies and percentages are reported for categorical variables. Group A: MWA + DEB-BACE + PD-1 blockade. Group B: MWA + DEB-BACE. Group C: DEB-BACE alone. DEB-BACE, drug-eluting bead bronchial artery chemoembolization; MWA, microwave ablation; NSCLC, non-small cell lung cancer; PD-1, programmed cell death protein 1.

no influence on the results and conclusions of this study. Despite all this, some essential corrigenda on these mistakes are still needed to avoid the potential misleading for more readers. The corrected numbers are listed in *Table S1*.

Finally, we appreciate these comments to optimize this manuscript and feel sorry for the mistakes of numbers in *Tab. 1* (2), despite these mistakes do not influence the conclusion. We believe corrigenda on these mistakes should be made to maintain the readability.

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