Reviewer 1:
Authors showed a very excellent survival for pT1N0M0 ESCC. As the authors mentioned, the recurrence rate for pT1N0M0 ESCC is higher than other gastrointestinal cancers. Detecting the metastasis as fast as possible is important to improve the prognosis. Therefore, this article is very interesting and meaningful.
1. Authors showed that cervical or upper thoracic tumor location has a high rate of cervical lymph node metastasis. You might be able to avoid it if 3-field lymphadenectomy was performed; however, the benefit of 3-field lymphadenectomy is still controversial. From your result, do you think that 3-field lymphadenectomy should be performed for cases with cervical or upper thoracic ESCC? Please discuss about it.

This is a decision for the surgeons to make. All we can do is report the results which we have found in these carefully evaluated cases and add them to the discussion of this issue. We think our results can add important data to this discussion.

2. Tumor located in the cervical should be excluded, because it has poorer prognosis than thoracic esophagus.

We agree. We have now removed that cervical case, and re-analyzed all the data accordingly.

Reviwer 3:
Hereby I would like to comment on the article entitled: "Clinicopathological Parameters Predicting Recurrence of pT1N0 Esophageal Squamous Cell Carcinoma" by the authors Li-yan Xue et al. The authors present recurrence rate of pT1N0 tumours in a large cohort of 218 patients in a single institute. This is a large series and more insight in recurrence patterns of T1 esophageal cancers is important to customize neoadjuvant and surgical treatment.

However, the retrospective nature of the study and the different surgical approaches used may be important confounding factors. For example, most "recurrences" were early and almost always in cervical and/or mediastinal lymph nodes. One could argue whether the surgical lymph node dissection was adequate in these patients. The authors need to address this issue and specify the exact surgical procedures with regard to lymph node dissection.

We studied the cases before 2004 when the endoscopic resection had not been performed yet in our hospital. It is true that many (18/47=38%) of the cases were "early" recurrences (diagnosed within 2 years after surgery). Actually, the surgeons would not perform surgery for those who had clinically cervical lymph node metastasis at that time. So we cannot be sure that they were not (actually, at least microscopically, but not clinically) present at the time of surgery. But they were not

identified before or at the time of surgery in our real-life clinical setting, using our current diagnostic techniques, so our results concerning which cases that are classified as pT1N0 by current clinical techniques are most likely to "recur" within 2 years (and thus should be followed for "recurrence" most closely) should be clinically useful to current-day surgeons using similar surgical techniques.

We have already said in the Abstract that these were two-field lymphadenectomies, and in the Methods/ Patients and surgical procedures that the McKeown and Sweet were performed for upper third, and middle/lower third, respectively. The cervical and upper mediastinal lymph node dissections are more difficult. The surgical lymph node dissection with these procedures were not adequate. But in most of the hospitals in China, the surgical procedures are still the same with ours.

We have now addressed the following in the discussion part: *We need to say that the fact that most (33/37=89%) of the patients in whom the locations of the recurrences were recorded had recurrences in the cervical and/or mediastinal lymph nodes raises the question of whether (macroscopic or microscopic) tumor was present at the time of surgery and could have been removed if a three-field lymph node dissection (including the cervical lymph nodes) or a more extensive two-field lymph node dissection (including more mediastinal lymph nodes) had been done. The optimal extent of the lymph node dissection in esophagectomies is an ongoing discussion among surgeons, and our data can contribute to this discussion.*

Furthermore, it is unclear how recurrence was measured. Did the authors perform scans/ endoscopies on a regular basis or did only symptomatic cases undergo further diagnostics.

We have now added this answer in the "Follow-up" section of the Methods as follows. *Follow-up and mortality data were mainly gathered from clinical notes. Patients were evaluated at return visits every 3 months during the first 2 years after treatment, every 6 months for the following 3 years, and annually thereafter according to hospital policy. At each visit, physical examination, endoscopic examination and CT scan of the cervix, chest and abdomen were performed. Recurrence of ESCC was confirmed either by CT scans or endoscopically. Suspicious recurrence were biopsied. Information about tumor recurrence was updated every time the patients came for a follow-up visit. For those patients who did not came for a follow-up visit, data were gathered from phone calls, and/or mail contact with patients or their next of kin. The patients were followed up for a median of 72 months and a maximum period of 263 months.*

Minor comments: The discussion needs to be shortened and repetition of results should be avoided.

We have now shortened the discussion according to the suggestion.