

## Answering Reviewers

### **Reviewer #1:**

**Q1.** This study is a cohort study, not a randomized controlled trial. Please describe how the participants were allocated to EOF group or Control group.

**A:** Thank you for your question. As you know, this study was not a randomized controlled trial, but a cohort study. In our center, there are two gastrointestinal surgery wards in department of general surgery. Patients enrolled in ward 1 were given early oral feeding (EOF group), and patients enrolled in Ward 2 were given traditional feeding (Control group). All patients were treated according to the gastric cancer treatment guidelines strictly and were given the same pre/post-operative intervention measures, except for dietary intervention strategies.

**Q2.** In comparison of quantitative data, the authors always used Student's t-test. If some of the data had nonparametric distribution, other statistical methods such as Mann-Whitney U-test should be alternatively used. Also, paired tests should be used properly.

**A:** Thank you for your reminder, we have re-checked and verified the statistical analysis methods involved in this study. For the independent sample quantitative data, we chose Student's T-test for comparison if it met the parameter test conditions, and Mann-Whitney U-test for comparison if it met the non-parameter test conditions. For the quantitative data of paired design, we chose paired T-test.

**Q3.** In table 3 and table 4, the total numbers of "tolerance of oral feeding after surgery" and "postoperative complications" are just the sum of the numbers of each component. Is there no overlap (e.g. a patient experiencing two or more complications)?

**A:** Regarding the above issues, we are very sorry for not making the question clear in the manuscript. We re-checked the original data and annotated related columns. In Table 3 and Table 4, as for whether there was overlap, our answer was "yes".

In Table 3, "Reinsertion of nasogastric tube" should be understood as patients with abdominal distension or nausea and reinsertion of nasogastric tube. 4 patients in the EOF group undergone reinsertion of nasogastric tube because of abdominal distension or nausea; and there were 3 cases in the Control group.

In Table 4, patients experiencing more than one postoperative complication were listed in the "other" row. 5 patients in the EOF group experienced more than one postoperative complication, and 2 patients in the Control group had more than one postoperative complication.

**Q4.** Table 5 and table 6 should be simpler. Odds ratios, confidence intervals and p-values will be all that we need. When describing odds ratios, please make it clear which is the denominator and which is the numerator.

**A:** Many thanks for the reviewer's suggestion and the table 5 and table 6 had been simplified accordingly. By default, the former was numerator.

**Q5.** The authors express some of the p-values as " $p>0.05$ ". It will be better to represent the actual p-values. Also, " $p=0.000$ " should be revised as " $p<0.001$ ".

**A:** Many thanks for the reviewer's suggestion. We had replaced all the " $P>0.05$ " expressions in the manuscript with the actual P-values. What's more, all " $P=0.000$ " expressions had been revised as " $P<0.001$ ".

**Q6.** In the discussion part, the authors repeated the background of their study, which already appeared in the introduction part. Discussion should be focused on what they found and learned, and comparison with previous evidence.

**A:** Thank you very much for your suggestions. According to your suggestion, we had deleted the repeated background content in the discussion part. And we re-wrote and refined the discussion part so that the discussion focused more on the new findings of our study and the similarities/differences between our findings and previous evidence.

#### **Reviewer #2:**

**Q:** Since the current controversies about the adoption of ERAS protocol in gastric surgery, I reckon a strictly assessment of the patient is mandatory. Among the ERAS criteria, malnourishing status plays a crucial role in choosing an early oral feeding after total gastrectomy; in order to better understand the role of an early oral feeding in preventing anastomotic leakage, that is the major complications after total gastrectomy, I think a mention about the nutrition state of gastric cancer patients is almost required.

**A:** Many thanks for your question and suggestion. Admittedly, the application of ERAS in gastric surgery is not a new topic. ERAS is a combination of more than 20 perioperative measures in the management of gastric cancer patients. On the one hand, early postoperative enteral nutrition support is one of the important content of ERAS, which plays an important role in many measures of ERAS. On the other hand, early enteral nutrition support can reduce postoperative stress response, reduce the release of inflammatory mediators, maintain intestinal mucosal barrier, prevent migration of intestinal flora, correct malnutrition of patients and enable gastric cancer patients to better accept measures of ERAS.

Undeniably, the implementation of ERAS requires screening of patients, and ERAS scheme is not applicable to all gastric cancer patients. However, the design of our study was not aimed to apply ERAS to patients enrolled. Considering the influence of malnutrition, diabetes and other factors on the incidence of postoperative complications such as anastomotic leakage, strict inclusion and exclusion criteria were implemented at the time of enrollment in this study. As illustrated in the manuscript, patients with diabetes, severe metabolic diseases or severe malnutrition were excluded.

After gastric cancer surgery, the Control group began oral feeding after the recovery of gastrointestinal function, while the EOF group began to receive low-dose and low-concentration enteral nutrition preparations in the early postoperative period, and the tolerance of oral feeding was evaluated dynamically, which was consistent with the recommendation of "Consensus of Chinese expert panel on perioperative nutrition therapy of gastric cancer".

We reviewed all patients' records. In this study, all the patients enrolled were screened by NRS-2002 for nutritional risk. And the portion of malnutrition between the two groups was similar (we added the patients' nutritional status in the "baseline data" in the manuscript).

As for the diagnosis of the extent of malnutrition, it is still controversial at present. In this study, patients with BMI <16 kg/m<sup>2</sup>, weight loss more than 5% within one month or more than 10% within six months, hemoglobin level < 60 g/L or serum albumin < 20 g/L were judged as severe malnutrition and were excluded.