Dear Editor,

We are grateful for your consideration of our article and the prompt and thorough review.

Our responses to the reviewers are below, point-by-point, with the changes in the manuscript highlighted in red:

Reviewer #1:
Scientific Quality: Grade A (Excellent)
Language Quality: Grade A (Priority publishing)
Conclusion: Accept (General priority)
Specific Comments to Authors: Thank you for the opportunity to review this excellent manuscript. SBRT is a new treatment for cholangiocarcinoma. The paper is a review of the application of SBRT in ICC. The author introduces the application and related clinical research progress of SBRT in ICC from the following aspects: (1) primary therapy in patients with technically resectable disease but precluded from resection due to medical comorbidities; (2) primary therapy in technically unresectable disease; this may be due to diffuse or metastatic disease; (3) recurrent disease after surgical resection; (4) following surgical resection to prevent local recurrence (adjuvant therapy), and (5) as a downstaging modality before surgery (neoadjuvant). The paper is rich in content, fluent in language and has high application value.

We are grateful for the positive comments and interest by reviewer #1.

Reviewer #2:
Scientific Quality: Grade C (Good)
Language Quality: Grade B (Minor language polishing)
Conclusion: Minor revision
Specific Comments to Authors: Overall, very well written manuscript on a lesser-known subject. I have a few suggestions below.

-Consider replacing SBRT with SABR (stereotactic ablative radiotherapy).

This has been replaced as suggested.

-Accuracy is between 2-3 mm. 5-10 mm is a bit generous. Generally speaking, a distance of 5 mm to luminal gastrointestinal organs is desired for "safe" dose escalation. Perhaps consider "ablative doses may be most easily achieved if located at least 5 mm from luminal organs". Reference: Koay PRO 2020 (PMID 32061993).

We have modified the sentence and added the reference.

-A few suggestions for the side effect profile section:

The side effect profile of SBRT in relation to the liver most commonly consists of [nausea and fever, which can be seen within a few hours of treatment. Give prophylactic antiemetics [Blomgren Acta Oncologica ‘95].

This has been added.

Late side effects of radiation includes radiation induced liver disease (RILD)..., which includes clinical symptoms of fatigue, elevated alkaline phosphatase (not transaminitis),

tender anicteric hepatomegaly and ascites. Non-classical RILD (usually in patients with underlying liver disease) is associated with elevated transaminase or jaundice, typically within 3 months of radiotherapy, consisting of liver enzymes more than five times the upper limit of normal or a decline in liver function as measured by worsening Child-Pugh score of 2 or more in the absence of classic RILD.] This occurs [less than 5%] of patients and is associated with cumulative [conventionally fractionated] doses higher than 30[-32 Gy in patients with normal liver function and 28 Gy for patients with underlying liver disease [QUANTEC]. There is no treatment for RILD, and it may occur as soon as 2 weeks or as late as 8 months after completion of treatment. Importantly, the liver regenerates after insult at a median time of 6-9 months.] (delete "in patients with known pre-existing liver disease"). Other specific toxicities are related to off-target effects on the gastrointestinal tract, with nausea, vomiting and diarrhea being common. Other effects are common to all radiation therapies, and these include skin necrosis and systemic effects such as fatigue and fever. [Skin toxicity is much less common in the era of volumetric modulated arc therapy (VMAT), which allows beams from 360 degrees and spreads out dose along the surface of the skin and has largely obviated any erythema resulting from treatment.] It should be reiterated that these side effects, when they do occur, are typically milder and less frequent than with equivalent conventional radiotherapy.[43]

We have modified the text with the above.

Please clarify: -Predictors of successful response were doses of radiation > 100 Gy. What does this mean? Is this a conversion in BED10 (alpha beta of 10)? If so, Please clarify e.g., write out doses "> 100 Gy-10 (BED10)". -"The reason is likely the lower radiation dose used at 45 Gy and the authors reported significantly higher survival with doses at >75 Gy" What does this mean? Is this a conversion in BED10 (alpha beta of 10)? Please clarify. -"...with a dose greater than 80.5 Gy" What does this mean? Is this a conversion in BED10 (alpha beta of 10)? Please clarify.

We have replaced these with the biologically effective doses (BED) as stated in the studies; the studies do not make mention of the alpha beta ratios.

An additional study to consider for Table 1: Kozak ARO 2020. https://www.sciencedirect.com/science/article/pii/S2452109419301149 Out of field failures in 23% of patients.

This has been added in text as well as in the table, with actuarial rates.

Consider adding a discussion on the utility of elective nodal irradiation to the portal hilar area. Speaking of elective nodal irradiation, it may be worth commenting on the difficulty of irradiation around the central biliary tree due to dose constraints: Osmundson IJROBP ’15 (PMID 25659885). Some common schemas for concerning portal hilar lymph nodes due to the tolerances of the central biliary tree may include 42 Gy in 15 fractions or, 35 Gy in 5 fractions, or 32 Gy in 3 fractions. For example, V66 Gy (BED10) corresponds to V40 and V37.7 for 5 fractions while V33.8 and V32 for 3 fractions. 5 fractions: V40 < 21cc, V37.7 < 24cc. 3 fractions: V33.8 < 21cc, V32 < 24cc. Please consider a few of the additions above.

Many thanks for this suggestion, this had been added following the discussion of Kozak et al.’s paper as they propose elective nodal irradiation.

Overall, this was an excellent report and I enjoyed the read. Congratulations on all your hard work!

Many thanks for your thorough and constructive review.

(1) Science editor:

According to the comments of reviewers, minor revision is needed.
Language Quality: Grade B (Minor language polishing)
Scientific Quality: Grade B (Very good)

(2) Company editor-in-chief:

I have reviewed the Peer-Review Report, full text of the manuscript, and the relevant ethics documents, all of which have met the basic publishing requirements of the World Journal of Gastrointestinal Oncology, and the manuscript is conditionally accepted. I have sent the manuscript to the author(s) for its revision according to the Peer-Review Report, Editorial Office's comments and the Criteria for Manuscript Revision by Authors. Please be sure to use Reference Citation Analysis (RCA) when revising the manuscript. RCA is an artificial intelligence technology-based open multidisciplinary citation analysis database. For details on the RCA, please visit the following web site: https://www.referencecitationanalysis.com/. Please provide decomposable Figures (in which all components are movable and editable), organize them into a single PowerPoint file. Please authors are required to provide standard three-line tables, that is, only the top line, bottom line, and column line are displayed, while other table lines are hidden. The contents of each cell in the table should conform to the editing specifications, and the lines of each row or column of the table should be aligned. Do not use carriage returns or spaces to replace lines or vertical lines and do not segment cell content. Please check and confirm whether the figures are original (i.e. generated de novo by the author(s) for this paper). If the picture is 'original', the author needs to add the following copyright information to the bottom right-hand side of the picture in PowerPoint (PPT): Copyright ©The Author(s) 2022. If an author of a submission is re-using a figure or figures published elsewhere, or that is copyrighted, the author must provide documentation that the previous publisher or copyright holder has given permission for the figure to be re-published; and correctly indicating the reference source and copyrights. For example, "Figure 1 Histopathological examination by hematoxylin-eosin staining (200 ×). A: Control group; B: Model group; C: Pioglitazone hydrochloride group; D: Chinese herbal medicine group. Citation: Yang JM, Sun Y, Wang M, Zhang XL, Zhang SJ, Gao YS, Chen L, Wu MY, Zhou L, Zhou YM, Wang Y, Zheng FJ, Li YH. Regulatory effect of a Chinese herbal medicine formula on non-alcoholic fatty liver disease. World J Gastroenterol 2019; 25(34): 5105-5119. Copyright ©The Author(s) 2019. Published by Baishideng Publishing Group Inc[6]". And please cite the reference source in the references list.

Many thanks. We confirm that the manuscript has been prepared in accordance with the journal's guidelines and we have used reference citation analysis.

We have also performed minor language polishing as recommended, with changes highlighted in the text.