Response to the comments of Reviewer 1：

Thank you very much for your valuable comments, which have greatly improved this manuscript. We have done our best to revise the manuscript. The responses were as follows:

1. Results of the Abstract. It seems clearer that the response rate of NAC was higher in patients with esophagogastric junction cancer, well and moderately differentiation, T2 and T3 cancer, histological differentiation, and lower CA724 value.

Answers to the specific comment: Thank you for your comment.

2. The authors did not present surgical results a lot. How about the relationship between the R0 resection rate and the tumor location, or CA724 value in patients receiving neoadjuvant chemotherapy?

Answers to the specific comment: Thank you for your comment. Table 4 and table 5 describe in detail the occurrence of postoperative complications. And this study was a retrospective study, and R0 resection after neoadjuvant chemotherapy was one of the inclusion criteria. R0 resection was performed in all patients. Therefore, the correlation of R0 excision with other factors cannot be discussed.

3. Can the authors describe about the relationship between the pathological response to NAC and other factors?

Answers to the specific comment: In section “Factors of NAC response”, we described about the relationship between the pathological response to NAC and the clinical data, include age, gender, BMI, blood group, tumor markers (CEA, CA125, CA199, CA724), tumor location, tumor size, depth of invasion, lymph node metastasis, pathological classification, albumin, platelet count, lymphocytes, neutrophils, monocytes, smoking history. Tumor size, depth of invasion and lymph node metastasis were evaluated on the basis of enhanced CT with laparoscopic exploration before NAC. The results are shown in Table 1, Figure 1, Figure 2, Figure 3,and Figure 3.

Response to the comments of Reviewer 2：

The authors conclude with 4 factors showed satisfactory predictive power to the response of NAC. On the other hand, what do we surgeons have to say from these results to advance our choice of treatment? With the four factors extracted, should we abandon NAC if they overlap? For example, if three of them overlap, or if all four overlap, is NAC ineffective? This study is

a follow-up study only for the last two years. Therefore, it would be more difficult to evaluate overall postoperative survival in patients who responded to NAC than in those who did not. On the other hand, it is possible to evaluate whether patients who responded to NAC underwent more gross radical surgery than those who did not. If so, what were the results? CA724 is a marker with many biases, as described by the authors. On the other hand, in the results of this study, the CA724 level was extracted as a factor indicating the effectiveness of NAC; could CA724 be used to determine the effectiveness of NAC treatment? At what level of CA724 was curative surgery possible?.

Answers to the specific comment: Thank you for your comment. The nomgram model has been widely used in recent years to predict medical outcomes, and as you know, it is only a mathematical model, which is bound to differ from the real situation. In this study, 4 intentional factors were considered, which included tumor location, histological differentiation, clinical T stage, and CA724. Each factor was assigned a corresponding risk score in the nomogram model. The physician is required to sum up these scores to determine the likelihood of neoadjuvant chemotherapy (NAC) for the patient and assist suitability for NAC.