Answering Reviewers

1、The topic of the paper is more in line with the reality, starting with solving the key clinical problems, the article has a certain clinical significance and use value, and has a certain degree of innovation.

Thank you very much. We appreciate you taking the time for reviewing this article.

2、The article collected 1968 patients, excluded 592 patients, and finally included 1106 patients. By scoring the relevant risk factors of the patients, a more reliable conclusion was drawn. But all the patients collected were consistent with the data analysis of the experiment? Whether the inclusion criteria can be detailed or not can further provide a prerequisite for the reliability of the experimental results.

The inclusion criteria and numbers of patients excluded by different reasons were mentioned in methods and presented in Figure 1.

3、In this article, patients with scores of 0, 1-2 and 3-7 were divided into low-risk group, medium-risk group and high-risk group. What is the basis for grouping? Whether it will have a different impact on the results.

Five predictors remained significant in multivariate analysis. With these factors, the score was calculated by assigning 2 points for platelet count, multiplicity, and TTV and 1 point each for albumin and ICG according to the calculation of the regression coefficient formula. The percentages of patients with risk scores from 0 to 7 were 28.3%, 13.0%, 28.4%, 15.3%, 9.3%, 4.3%, 1.3%, and 0.1%, respectively. Patients with 0, 1–2, and 3–7 points were categorized into low-, intermediate-, and high-risk groups, according to the ascending possibility of the 16th, 50th, and 84th percentiles. Our decision on these cut-off centiles were referred to the following article: Royston, P., Altman, D.G. External validation of a Cox prognostic model: principles and methods. BMC Med Res Methodol 13, 33 (2013). https://doi.org/10.1186/1471-2288-13-33 We've also tried different grouping strategy such as decision tree, but not much difference was found in the results.

4、This paper uses a large number of cases for statistical analysis, but the use methods and statistical methods are relatively vague, resulting in a large number of experimental results appear directly in the paper, which makes it difficult for readers to understand.

Thanks for your kind reminder. After significant variables associated with DFS were identified in the multivariate Cox proportional hazards model, scores were assigned to each prognostic predictor according to the results of the regression coefficient formula. And total points were categorized into low-, intermediate-, and high-risk groups, according to the ascending possibility percentiles as mentioned above.

5、The writing train of thought of this paper is clear, the text is smooth, and the writing format and the citation of charts, characters and documents are in line with the standard.
Thank you very much.

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1. The manuscript discussed clinical insignificant for current preoperative score of hepatocellular carcinoma. The C-index was 0.617, which was higher than the Tokyo score (0.613), the Taipei Integrated Scoring System (0.562), and equal to the value of the AJCC 8th (0.617). The modified preoperative score provides an easier way to predict disease free survival for hepatocellular carcinoma patients with surgical resections.
Despite a C-index lower than 0.7, it's a large sample from the real world. We hope this simple score can benefit clinical assessment.
2. The language quality in the manuscript is good.
Thank you very much.
3. Predictive modeling is a classic and the sample is large. However, some preoperative serological indicators were missing.
Thanks for your kind reminder. We'll collect more data in the further.