We sincerely thank the reviewers for their detailed and thoughtful feedback, which has helped us substantially improve the clarity and depth of our commentary. Below, we provide point-by-point responses outlining how each issue was addressed in the revised manuscript.

Reviewer 1

Reviewer Comment 1:

The manuscript reads more like a mini-review. Redundant explanatory sections (e.g., basic description of decision trees, general ML advantages) should be deleted.

Response:

We appreciate this observation. The redundant explanatory sections describing general machine learning (ML) advantages and basic algorithmic concepts have been removed to make the manuscript more concise and focused on the commentary.

Revised section:

The paragraph beginning with "Machine learning (ML) is revolutionizing modern medicine…" has been deleted.

Reviewer Comment 2:

Clearer positioning: The introduction or abstract should explicitly state that this is a commentary or reflection on a published study, not a research article or full review. Suggested opening sentence: "We read with great interest the recent study on ML-based risk prediction for delayed wound healing after gastrectomy, and wish to highlight both its promise and limitations."

Response:

We agree and have revised the introduction accordingly. The suggested sentence has been added at the beginning of the introduction to clearly establish the purpose and format of the manuscript.

Added sentence:

"We read with great interest the recent study on ML-based risk prediction for delayed wound healing after gastrectomy, and wish to highlight both its promise and limitations."

Reviewer Comment 3:

Targeted referencing: Some references (e.g., [3] FATIMA, Sheraz...) are not sufficiently authoritative. Replace with references from leading medical journals or reviews.

Response:

We agree and have removed the non-authoritative reference ([3] FATIMA, Sheraz). Additionally, since the related explanatory section was deleted (per Comment 1), this reference is no longer relevant. The remaining citations now focus on peer-reviewed articles from leading medical journals.

Reviewer Comment 4:

Result presentation: The phrasing "excellent AUC of 0.951 and identified all cases" may mislead readers into thinking these are the authors' own results. It should be revised to: "The study reported an AUC of 0.951, with all cases of DWH correctly identified at the Youden threshold."

Response:

We thank the reviewer for this helpful clarification. The suggested wording has been adopted verbatim to ensure accurate attribution of the findings.

Revised sentence:

"The study reported an AUC of 0.951, with all cases of DWH correctly identified at the Youden threshold."

Reviewer Comment 5:

More concise conclusion: The current conclusion reads like a review. It should be shortened to 2–3 sentences summarizing the core commentary.

Response:

We agree and have completely rewritten the conclusion to be concise and commentary-focused. The revised conclusion highlights the key message of the letter.

Revised conclusion:

"The study demonstrates the promise of machine learning, particularly interpretable decision tree models, for predicting delayed wound healing after gastrectomy. However, its reliance on postoperative variables and single-center design limits

generalizability and clinical applicability. Future studies should focus on multicenter external validation and the inclusion of preoperative predictors to enable earlier, actionable risk assessment."

Reviewer 2

Reviewer Comment 1

Why is delayed wound healing (DWH) an important complication after radical gastrectomy?

Response:

We agree with the reviewer that clarifying the clinical significance of DWH strengthens the context of the commentary. Accordingly, we have added the following statement to the introduction:

"Delayed wound healing after radical gastrectomy can lead to prolonged hospitalization, increased infection risk, delayed adjuvant therapy, and higher healthcare costs, underscoring the importance of early risk identification."

Reviewer Comment 2

Which machine learning algorithm performed best in the study, and what was its AUC value?

Response:

We have added a clear description of the model's performance to accurately summarize the referenced study:

"A decision tree model demonstrated excellent discrimination, achieving an AUC of 0.951 in the validation set and notably identifying all true cases of DWH at the Youden index threshold."

Reviewer Comment 3

What are the key clinical and laboratory parameters included in the model?

Response:

The revised text now includes the principal predictors used in the model:

"The model incorporated both clinical and laboratory variables, including drainage duration, preoperative neutrophil count, albumin level, and patient demographics, reflecting a comprehensive view of surgical and physiological risk factors."

Reviewer Comment 4

What clinical benefits arise from early detection of patients at high risk for DWH?

Response:

We have addressed this point by adding a sentence explaining the clinical impact of early detection:

"Early identification of patients at high risk for DWH enables timely nutritional optimization, wound management, and closer postoperative monitoring, potentially reducing complications and improving recovery outcomes."

Reviewer Comment 5

Why is drainage duration considered a limitation in terms of predictive usefulness?

Response:

We added an explicit explanation of this limitation:

"Because drainage duration is only known after surgery, its inclusion limits the model's ability to predict DWH preoperatively—when preventive measures would be most useful."

Reviewer Comment 6

What makes decision trees computationally efficient and suitable for clinical practice?

Response:

We clarified this technical point as follows:

"Decision trees require minimal computational resources and produce easily interpretable decision rules, making them suitable for real-time use in clinical settings."

Reviewer Comment 7

What are the limitations of validating the model only in a single center?

Response:

We have added a statement emphasizing generalizability concerns:

"Single-center validation restricts the generalizability of findings, as variations in surgical practice, patient populations, and data collection methods can significantly affect model performance."

Reviewer Comment 8

How can external validation and multicenter studies improve the robustness of ML models?

Response:

We incorporated this suggestion into the discussion section:

"External validation across multiple institutions would improve robustness, detect potential overfitting, and confirm that the model maintains accuracy across diverse clinical environments."

Reviewer Comment 9

Before advocating for ML integration, is there evidence that this decision tree model performs significantly better than a simple logistic regression model?

Response:

We agree that comparative analysis is essential for justifying ML adoption. The following statement was added to address this concern:

"Before advocating for broad clinical use, comparative analyses with conventional models such as logistic regression are necessary to demonstrate that machine learning offers a meaningful performance advantage rather than added complexity alone."

Reviewer Comment 10

The conclusion mentions the integration of ML into care. What are the potential ethical and practical hurdles?

Response:

We have expanded the conclusion to briefly address the ethical and practical aspects of ML integration:

“Integrating ML models into clinical care raises practical and ethical considerations, including potential algorithmic bias against underrepresented populations, data privacy concerns, and the need for interoperable electronic health record systems capable of supporting real-time risk scoring.”

All queries were handled appropriately, and the paper is now accepted for possible publication.
Reply: Thanks for your comments.