Author's Response for Comment on "Gastrointestinal Bleeding in Small Intestinal Stromal Tumors: A Clinicopathological and Survival Analysis"

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Dear Editor,

We have read the reader's comment letter. Subsequently, we immediately retrieved all original pathological reports, hospital electronic medical records and raw SPSS statistical outputs for a comprehensive re-evaluation. Below is a full explanation addressing the two inconsistencies regarding Ki-67 index raised by the reader, including the root cause of errors and a complete revision plan. We offer our sincere apologies for our careless proofreading.

1. Root Cause of Discrepancies: Typographical Errors in Table 1

After cross-checking the Ki-67 pathological records of all 152 patients diagnosed with small intestinal stromal tumors, the true stratified data are as follows:

A total of 152 participants were enrolled, divided into a gastrointestinal (GI) bleeding group (n=47) and a non-GI bleeding group (n=105).

- GI bleeding group: 24 patients with Ki-67 ≤5%, 23 patients with Ki-67 >5%; the proportion of high Ki-67 expression was approximately 48.9%.
- Non-GI bleeding group: 63 patients with Ki-67 ≤5%, 42 patients with Ki-67 >5%; the proportion of high Ki-67 expression was 40.0%.

During table compilation, we mistakenly typed 83 instead of the actual count 42 for patients with Ki-67 >5% in the non-bleeding cohort. This single transcription mistake triggered both sets of numerical inconsistencies pointed out by the reader, which we explain separately below.

2. Response to the First Concern: Contradiction Between Main Text and Table 1 Caused by Typo

Due to the incorrect figure "83" entered for Ki-67 >5% cases in the non-bleeding group, Table 1 falsely calculated a high Ki-67 expression rate of 79.0% for non-bleeding patients, which appeared to contradict our statement that GI bleeding patients demonstrated stronger Ki-67 proliferative activity.

Based on authentic raw data, the proportion of Ki-67 >5% cases reached 48.9% in the bleeding group, higher than the 40.0% recorded in non-bleeding patients. The textual description in the manuscript accurately reflects the real pathological distribution of our cohort and contains no logical errors. All conflicts arise solely from the wrong values filled in Table 1.

3. Response to the Second Concern: Mismatched Stratified Counts Between Table 1 and Table 2

The univariate survival analysis (Table 2), Kaplan–Meier survival curves and Cox proportional hazards regression model were all computed using the genuine Ki-67 stratification data from the full 152-patient cohort:

Overall, the total number of patients with Ki-67 ≤5% equaled 24 + 63 = 87, while those with Ki-67 >5% totaled 23 + 42 = 65. These figures perfectly match the stratified sample sizes listed in Table 2. All survival curves, Log-rank test results and multivariate regression outputs are authentic and valid. The core conclusion that Ki-67 acts as an independent adverse prognostic factor remains unaffected by the table typo.

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If Table 1 had been filled correctly, its aggregated Ki-67 counts would align with Table 2 (87 cases for Ki-67 ≤5%, 65 cases for Ki-67 >5%). However, the erroneous entry of "83" for non-bleeding patients with Ki-67 >5% generated false aggregate totals of 46 Ki-67 ≤5% cases and 106 Ki-67 >5% cases, creating a severe numerical mismatch between the two tables and misleading the reader.

4. Confirmation of Raw Data Authenticity

All anonymized original pathological materials of enrolled patients were previously submitted to your editorial office for inspection. There is no fabrication or alteration of clinical data in this study.

All survival analyses and multivariate prognostic models were performed using the accurate 87 vs. 65 Ki-67 stratification dataset. The prognostic predictive value of Ki-67 is solid and credible.

5. Full Revision Plan

1. We have corrected two erroneous values in the non-GI bleeding subgroup: change the false count 22 of Ki-67 ≤5% to the true value 63, and amend the incorrect number 83 of Ki-67 >5% to 42. Meanwhile, update the corresponding F-value to 1.059 and P-value to 0.303 for the Ki-67 variable.
2. We have revised the baseline intergroup comparison sentence.
   Original text was "No significant differences were found between the GI bleed ing group and the non-bleeding group in age, gender, tumor size, nuclear division count, tumor necrosis, CD34 positivity, CD117 positivity, KIT gene mutation status, or duration of imatinib treatment (P > .05). However, sig nificant differences were observed in tumor rupture and Ki-67 percentage (P < .05) (Table 1)."
   Now, the revised manuscript reads as "No significant differences were found between the GI bleeding group and the non-bleeding group in age, gender, tumor size, nuclear division count, tumor necrosis, CD34 positivity, CD117 positivity, Ki-67 percentage, KIT gene mutation status, or duration of imatinib treatment (P > .05). However, significant differences were observed in tumor rupture (P < .05) (Table 1)."
3. The relevant sentence in the Discussion section was also revised. The original version stated, "This discrepancy may stem from the significantly higher tumor rupture rate (15.2% vs. 3.8%, P = .048) and elevated Ki-67 expression (68.1% vs. 51.4%, P = .032) in the bleeding group [...]". It now reads as "This discrepancy may stem from the significantly higher tumor rupture rate (17.0% vs. 6.7%, P = .048) and elevated Ki-67 expression (48.9% vs. 40.0%, P = 0.303) in the bleeding group."

We also corrected the miscalculated percentages for tumor rupture, which does not alter the statistical significance of the result.

4. All descriptions of Ki-67 stratified case numbers throughout the full manuscript have been standardized to guarantee consistent and coherent data across the main text, all tables, survival figures and regression results.
5. We will implement a double cross-check procedure for all statistical data in all future manuscripts submitted by our team, to prevent similar transcription mistakes.

We sincerely apologize for the unnecessary extra workload this table proofreading error has brought to your editorial team, peer reviewers and readers. We appreciate the rigorous scrutiny from the reader and the opportunity your journal has granted us to clarify and revise our manuscript.

Best Regards,