

### Author Response 3

#### Reviewer 2

1. The authors mention that this procedure makes the identification of nodules more expeditious. It would seem to me that is a bit of a stretch and implies to the reader that they are likely placing wires in nodules that could likely be palpated. The key with this technology is to find a balance, use it when you identify a nodule that you believe you could not palpate, not to use it on every nodule available. In my practice, I use a localization for peripheral nodules, usually under 1.5 cm, that are predominately ground glass. Given that the indication for pursuing such nodules is low, the need for the technology, in my opinion, is limited. Localizing a 2-3 cm solid peripheral lesion seems to me like a waste of resources. It would be nice if the authors could address this issue somehow in their discussion as this issue will be in the back of readers minds.

Answer: Thanks for your comment.

If we planned to perform the VATS-guided wedge resection, the coil localization was usually performed. However, there was a prerequisite, which was that the nodule had no definite pathologic diagnosis.

In our hospital, for a 1-3 cm solid peripheral lesion, we usually performed the CT-guided lung biopsy to make a pathologic diagnosis. If the biopsy indicted a malignant result, we directly performed VATS-guided lobectomy, which did not require coil localization. If the biopsy indicted a benign result, the routine CT follow-up was usually performed. Therefore, most of the solid peripheral lesions with 1-3 cm did not require wedge resection. For a solid nodule < 1 cm, the technical difficulty for lung biopsy is very high, therefore, we usually performed diagnostic wedge resection with the coil localization.

For the sub-solid nodules, the lung biopsy was not suggested [1]. If the diagnostic wedge resection was planned to perform, the coil localization was performed for all sub-solid nodules due to the soft nature.

We reviewed our data again. In this study, most of the nodules were sub-solid nodules, the solid nodules were all less than 1 cm.

We also added some discussion about that coil localization for larger solid nodules is limited used.

1. Bankier AA, MacMahon H, Goo JM, Rubin GD, Schaefer-Prokop CM, Naidich DP. Recommendations for Measuring Pulmonary Nodules at CT: A Statement from the Fleischner Society. *Radiology*. 2017 Nov;285(2):584-600.