PART 1:Article Title: "FEASIBILITY AND EFFECTIVENESS OF MULTICHANNEL FUNCTIONAL ELECTRICAL STIMULATION ON UPPER EXTREMITY MOBILITY AND FUNCTION DURING STROKE REHABILITATION- A PILOT STUDY"

	Editor's comment	**Author's comment***(If agreed with the editor, correct the manuscript and highlight that part in the manuscript. Authors must write his/her feedback here)*
Is the manuscript important for the scientific community? Please write a few sentences explaining your answer	**Yes, with caveats.** Early, coordinated multichannel FES during inpatient stroke rehab is clinically relevant and under-studied. The pilot adds preliminary signals of benefit (shoulder flexion AROM, ARAT, mPSFS) and confirms basic feasibility within therapy time. That said, small sample size, analytic choices (one-tailed tests), unclear handling of "unable to complete" outcomes, and missing/unclear reporting limit interpretability. Strengthening methodology and reporting will increase value.	
Is the title of the article suitable? Do you have any alternative Title in your mind?	The title is accurate but can be tighter and more informative. **Suggested alternatives** 1. "Feasibility and preliminary effects of multichannel FES plus task-specific training on upper-extremity outcomes during inpatient stroke rehabilitation: a pilot randomized study." 2. "Multichannel FES in early inpatient stroke rehabilitation: feasibility and pilot randomized results for upper-extremity mobility and function."	
Is the abstract of the article comprehensive? If your answer is No, please provide suggestions	**Partly.** It communicates design, intervention, and headline findings, but should better reflect the pilot intent and improve transparency. **Revise as follows:** • State **randomized pilot** design explicitly, with **n per arm**. • Identify a **primary outcome (or explicitly state there wasn't**	

	one) for a pilot aimed at estimation/feasibility. • Report **adherence/feasibility metrics quantitatively** (e.g., % sessions delivered; mean setup time with SD). The text says "manageable," and discussion mentions "<15 min," but no numeric result is presented in Results. • Emphasize **effect sizes and 95% CIs** rather than p-values (especially one-tailed). • Clarify handling of outcomes that many participants **could not complete** at baseline (NHPT/BBT)—do not code "unable" as 0 seconds (NHPT). • Consider a concluding sentence that clearly frames findings as **preliminary signals** that inform design of a larger trial.	
Do you think the English quality of the article is suitable for scholarly communications? If your answer is No, please provide suggestions	**Mostly adequate, but several phrasing/consistency issues and typos need correction. Examples:** • "Onset of stroke **at least less than** 3 months…" → "Onset of stroke **<3 months** before enrollment." • "A **had held** dynamometer" → "a **hand-held** dynamometer." • Standardize tense and capitalization (e.g., "Intervention," "Outcome Measures"). • Ensure spacing and punctuation around units and parentheses are consistent (e.g., "10.12(1)" appears malformed in Table 2; likely "10.12 (—)"). • Replace informal claims like "manageable" with quantitative data. • Use consistent device/manufacturer citations	

	(see References).	
Please provide your comments regarding the appropriateness of different sections of the manuscript.	**Introduction** • Strong clinical rationale; the muscle synergy rationale for multichannel FES is well motivated. • Please **tighten the literature review** to focus on gaps specific to **multichannel** FES in the **inpatient/subacute** phase. • Clarify novelty (e.g., "to our knowledge, no randomized pilot… during inpatient phase targeting coordinated proximal+distal activation"). • If a **primary outcome** exists, state it here (even in a pilot), along with feasibility endpoints. **Methods** • **Design/registration:** State whether the pilot RCT was **prospectively registered**; if not, justify (journal may still prefer registration for RCTs—even pilots). • **Randomization:** "Lot-drawing" needs detail and **allocation concealment** (who generated sequence; who enrolled/assigned; method to prevent foreknowledge). • **Blinding:** Assessors were not blinded—acknowledge as a limitation; consider feasibility of assessor blinding in future trials. • **Intervention dose:** You note "30 min/day, 4 days/week, 2 weeks" (≈8 sessions). Report **actual sessions delivered per participant** and **setup time** (mean±SD). • **Usual care:** Define/control **content and dose** (minutes; OT/PT split) to ensure groups are comparable apart from FES.	

	• **Outcomes:** For measures with **non-completers** (NHPT/BBT/ARAT), pre-specify rules for scoring; do **not** code "unable" as **0 seconds** for NHPT (0 s is physiologically impossible and inverts meaning—lower is faster). Consider binary "able/unable" analyses or appropriate imputation/sensitivity analyses. • **Statistical analysis:** o Justify or avoid **one-tailed tests**; two-tailed is standard unless a priori justified and registered. o Given small n, focus on **estimation**: report **mean change with 95% CIs** and **effect size CIs**. o Consider **ANCOVA** (post-test adjusted for baseline) rather than change-score t-tests; it's more efficient and robust in small samples. o Address **multiplicity** (many outcomes) and clarify that findings are **exploratory**. o Clarify **missing data handling** for participants unable to complete tests. o Remove statements implying robustness of parametric tests without support in such small samples; when normality is violated and n is tiny, use **non-parametric** or permutation approaches, or present only descriptive stats with CIs. **Results** • Provide a **CONSORT flow**	

	diagram for pilot RCTs (screened, eligible, randomized, analyzed). • **Figures 1–3 are referenced but missing.** Please include them or remove references. • Correct **Table inconsistencies/typos** (e.g., NHPT pre-test "0 (0)" for Xcite suggests miscoding; BBT Traditional group p value listed as "1.0" in Table 3; several SD/formatting anomalies like "10.12(1)"). • Add **feasibility metrics** quantitatively in Results (sessions delivered, setup time, zero missed appointments, adverse events). **Discussion** • Temper causal language: avoid "effective/efficacy" and use "**preliminary signals** consistent with potential benefit." • When invoking neuroplasticity mechanisms, keep concise and **tie to observed tasks** (shoulder flexion gains align with reach task specificity). • Clarify MCID use (e.g., ARAT MCID in early stroke) with **CIs** to avoid over-interpretation. • Explicitly discuss **limitations**: small sample; unblinded assessors; analytic choices; handling of non-completers; short duration; usual care variability; unregistered RCT (if applicable). • Add a short **future-trial blueprint** (sample size estimate based on observed effect sizes; stratification by impairment severity; standardized "dexterity-focused" FES activities; assessor blinding;	

	core feasibility metrics and PROs). **Feasibility** • Good operational definition but needs data. Report: sessions planned vs delivered; mean setup time (±SD); any **adverse events**; staff burden/acceptability.	
Do you think that the references in the manuscript are proper, recent and sufficient? If you have any suggestions, please write here.	□ Several entries are **incomplete or inconsistent** (e.g., "Heart Disease and Stroke Statistics—2023 Update" listed as n.d.; "Patient-Reported Outcome Measures…" lacks authors; "Restorative Therapies" via "Gateway Biosciences" looks like a distributor page rather than manufacturer—cite the **device manufacturer** and model with location). □ Consider adding recent **multichannel FES** or synergy-based FES trials if available; otherwise emphasize gap. □ Ensure **MDC/MCID sources** match the population/timeframe used in interpretation. □ Standardize formatting (journal style) and verify all DOIs.	

PART 2:

	Editor's comment	
Are there ethical issues in this manuscript?	*(If yes, Kindly please write down the ethical issues here in detail)* □ IRB approval and consent are stated. No obvious ethical violations. □ For RCTs, confirm **trial**	

	registration status; if unregistered, disclose and justify (journal policy dependent). □ Disclose whether the device was **loaned, discounted, or supported** by the manufacturer; if so, include funding/COI statements and role of funder.	
Are there competing interest issues in this manuscript?	Authors declare none. Given use of a **named commercial device (Xcite)**, please explicitly state any **in-kind/device support** or confirm **none**.	
Do you think the article is plagiarized? If yes, please justify your answer and send us some proof.	No obvious text overlap detected on read. Routine editorial checks recommended.	
Do you think a Disclaimer is required to explain the history of this manuscript? (As in most cases chapters of reference books are extended versions of previously published articles in some journals)	Not necessary unless parts have been previously published; authors should confirm originality.	

PART 3: Declaration of Competing Interest of the Editor:

Here reviewer should declare his/her competing interest. If nothing to declare he/she can write "I declare that I have no competing interest as a reviewer" I declare that I have no competing interest as a reviewer.

PART 4: Objective Evaluation:

Guideline	MARKS of this manuscript
Give OVERALL MARKS you want to give to this manuscript	**7/10**

(Highest: 10 Lowest: 0) **Guideline:** Accept As It Is: (>9-10) Minor Revision: (>8-9) Major Revision: (>7-8) Serious Major revision: (>5-7) Rejected (with repairable deficiencies and may be reconsidered): (>3-5) Strongly rejected (with irreparable deficiencies.): (>0-3)	Key action list for authors (prioritized): 1. Correct outcome handling: Recompute NHPT/BBT/ARAT analyses to properly handle non-completers (do not code "unable" as 0 sec for NHPT); consider responder analyses (able vs unable), and provide CIs. 2. Revise statistics: Use two-tailed tests or justify one-tailed a priori; emphasize effect sizes with 95% CIs; consider ANCOVA; clarify multiplicity as exploratory. 3. Complete Results assets: Provide CONSORT flow, Figures 1–3, and fix table errors (typos, malformed numbers, SDs, p values). 4. Feasibility data: Report adherence (sessions delivered/planned), setup time (mean±SD), and adverse events. 5. Usual care detail: Describe/control dose/content to isolate the added value of FES. 6. Registration/COI: State trial registration (or justify absence) and device funding/support status explicitly. 7. Abstract rewrite: Reflect pilot/feasibility aims; add n per group, key effect sizes with CIs, and quantitative feasibility metrics. 8. Language and formatting: Fix grammatical items; standardize units/formatting; harmonize references (complete citations, manufacturer citation for device). 9. Title/claims: Temper efficacy language throughout; position as pilot signals informing a definitive trial.