

## Peer Review File

Article information: <https://dx.doi.org/10.21037/ales-22-45>

### Reviewer Comments

Comment 1: Thank you for submitting this manuscript for a review.

The paper discusses rare case of an umbilical Littre's hernia with incarceration of Meckel's diverticulum.

The paper is concise, well written, in a proper layout with good presentation of a technique and detailed description of an undertaken management.

The Discussion however lacks some issues regarding other options of possible treatment alternatives, as this patient was at high risk of recurrence due to obesity.

New minimally invasive techniques of hernia repairs with a use of microporous mesh (doi: 10.5604/01.3001.0014.9349) could be helpful in the management of this complication, allowing to reduce the use of primary suture – please elaborate on this topic (please consider using the following references: doi:

10.5604/01.3001.0014.1898 and DOI: <https://doi.org/10.5114/wiitm.2021.110415> ).

Reply 1: The other possible treatment alternatives for umbilical hernia in this high-risk patient have been included in this latest revision, specifically in the last paragraph of the discussion section. Please consult the discussion section for further explanation of the possible treatment alternatives and the reasoning for the avoidance of mesh in this case.

Comment 2: The authors describe the case of a middle-aged patient who was incidentally found to have a Meckel's diverticulum within an umbilical hernia sac. They describe the pre-operative, operative and post-operative course with varying degrees of detail. The rarity of the case presented means that it would be of interest to the general reader, although the authors have not articulated any learning points that would be of use. Some points that I would like to see addressed:

- (a) More detail on the operative strategy - port placements for the initial laparoscopy, any further ports inserted once the adherent mass was found, timing of conversion to open (if indeed a conversion was undertaken).
- (b) A scale bar/ruler for the operative specimen in Figure 1. It is hard to gauge the size of the specimen from this figure. At the very least, a description of the size of the specimen in the main text, along with the size of the hernial defect would be useful.
- (c) If a malignancy was suspected (line 66), was the resection performed with adequate thought to resection margins and lymph node stations?
- (d) Line 76 - absorbable or non-absorbable suture? Size of the suture.
- (e) Kerlix is probably a brand name - could you please describe it without the brand name?
- (f) Line 78: any more pathological descriptors? Any malignant foci present? Ectopic glands?
- (g) Line 80: on what post-operative day was the patient discharged?

- (h) Any intraoperative pictures would be of interest to the reader.
- (i) Line 135-136: . "In reference to the use of mesh, one systematic review of 53 cases reported use of mesh in only 17% of cases." This statement is so vague. 53 cases of what? Littre's hernia or small bowel resections? What was the outcome of these 17% of cases? How many got infections and how many didn't? Is this good enough to justify not using a mesh? What is the recurrence rate of hernia without mesh in this systematic review? There is some decent recent literature that supports the use of mesh even with a bowel resection and this is worth citing.
- (j) Are there any learning points that general readers can take from your experience of this case?
- (k) Your discussion is very centred on Meckel's diverticulum, and very little on Littre's hernia, and even less so on Littre's hernia at the umbilicus. I appreciate that there isn't much literature on this subject but there must be some learning points on the 9 cases so far.

Reply 2: Further details on the operative strategy, including port placements, have been included in the second paragraph of the case description. Please consult the highlighted sections of the case description for more information on the specific operative strategy employed in this patient. A description of the size of the specimen resected has also been included. The reasoning for the small bowel resection in this hernia repair case has been included. The primary reason for the small bowel resection was due to these concerns of malignancy. The suture and bandages have been further described as well. Further details about the risk-benefit analysis of mesh use have been included in the last two paragraphs of the discussion. Since Littre's hernia remains an incredibly rare entity, proper management of such cases varies significantly and should be determined on a case-by-case basis.

Comment 3: Please change the pronoun in line 154.

Reply 3: The pronoun has been changed. Thank you for pointing this out to us.

Comment 4:

- (a) Why not ultrasound examination?
- (b) what about trocar site LH?
- (c) which technique should be given preference - open or laparoscopic?
- (d) diverticulum/small bowel inflammation - what about use of mesh?

Reply 4: Ultrasound was not readily available during the treatment of this patient. However, ultrasound remains a solid option for pre-operative investigation of hernias like this one. Trocar sites have been included in the case description as mentioned above. The decision-making thought process concerning open vs laparoscopic approach and the use of mesh has been included in the second half of the discussion. Please consult the highlighted portions of the discussion for the full commentary on those surgical management issues.