

## Peer Review File

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### Reviewer A

The present paper is an interesting report, but lacks originality, novelty, and significance. There are already findings of 5mm trochanteric site hernias as a rare but possible event. PMID: 32728766

Reply 1: We appreciate your comments. The presence of hernias in 5 mm trocars is very unusual and can go unnoticed, but we must keep this clinical suspicion in mind. In cases with high risk and excessive manipulation of the 5 mm trocar, we must try to close the trocars site, so we believe it is worth highlighting to prevent it from happening.

This complication, although rare, can appear in the transabdominal approach to inguinal hernias, however, it does not occur with an extraperitoneal approach (TEP) and to the best of the authors' knowledge, it is the first obstruction described in a 5 mm trocar after a TAPP repair.

Changes in the text:

### Reviewer B

**Comment 2:** The authors report a 5 mm trocar site incarcerated hernia after TAPP, although requires modification prior to consideration of publication. As this is a case report, I suggest that you report on the case in more detail.

At the time of the first inguinal hernia surgery, when the port is removed, you should always check the abdominal wall after removal to check if there is any bleeding or large defects. I think it would be better to specify whether this was done or not this time. This is very important.

Another picture of this time would be even better.

If you did not check, you should add a discussion.

**Reply 2:** We routinely check the abdominal wall after removal of any trocar to verify there is no bleeding or large defects. In this case the abdominal wall was checked as usually.

There is no picture of this moment because it was performed after the first TAPP hernioplasty performed as a scheduled surgery.

**Changes in the text:** We add to the case presentation “We routinely check the abdominal wall after removal of any trocar to verify there is no bleeding or large defects. In this case, the abdominal wall was checked as usually.”

**Comment 3:** Was the type of hernia Richter type?

**Reply 3:** Yes, it was a Richter hernia.

Richter hernia is a herniation of the anti-mesenteric portion of the intestine through a fascial defect, the incidence of Richter's hernia has been increasing with the growing popularity of minimally invasive surgery.

**Changes in the text:** we add in introduction; “Richter hernia is a herniation of the anti-mesenteric portion of the intestine through a fascial defect, the incidence of Richter's hernia has been increasing with the growing popularity of minimally invasive surgery and our patient suffered a Richter hernia after a TAPP inguinal hernioplasty. “

**Comment 4:** Why was the CT evaluation performed 24 hours after the patient's arrival, even though the patient was found to have symptoms of intestinal obstruction with abdominal pain in the early postoperative period? Did they first suspect other diseases? In some cases, could it lead to necrosis of the mated intestinal tract? We request that an explanation be added to the process leading up to the diagnosis.

**Reply 4:** The patient arrived to the emergency room and during the first 24 hours was managed conservatively with placement of a nasogastric tube by emergency doctors. Twenty-four hours after admission to the emergency room, the patient continued to be distended and had no bowel movements, so an abdominal CT scan was performed that showed a small intestine herniation through a 5mm laparoscopic trocar incision in the left flank (image 1) leading to a mechanical obstruction. The surgical team met the patient after de CT scan. This complication may go unnoticed; therefore, it is important keep this clinical suspicion in mind to diagnose early because time can affect the viability of the involved portion of the bowel.

**Changes in the text: We change the text** “On the third postoperative day, the patient arrived to the emergency room due to diffuse abdominal pain and vomiting during the previous 6 hours. An abdominal X-ray was performed. X-ray findings were suggestive of bowel obstruction including dilated loops of bowel with air–fluid levels. It was initially managed conservatively with placement of a nasogastric tube by emergency doctors. Twenty-four hours after admission to the emergency room, the patient continued to be distended and had no bowel movements, so an abdominal CT scan was performed that showed a small intestine herniation through a 5mm laparoscopic trocar incision in the left flank (image 1) leading to a mechanical obstruction. The surgical team met the patient after de CT scan. This complication may go unnoticed; therefore, it is important keep this clinical suspicion in mind to diagnose early because time can affect the viability of the involved portion of the bowel.”

**Comment 5:** It would be better to make the Conclusion concise. It is good in the discussion, but I think the Conclusion should focus on conveying the most important

points you want to make.

**Reply 5 We Change the conclusion** “The presence of hernias in 5 mm trocars is very unusual and can go unnoticed, but we must keep this clinical suspicion in mind. This complication can appear in the transabdominal approach to inguinal hernias; however, it does not occur with an extraperitoneal approach (TEP).

The use of the laparoscopic approach for repair of incarcerated/incisional hernias is increasing, as it is a safe technique with the advantages of being a minimally invasive surgery.”

**Changes in the text:** The presence of hernias in 5 mm trocars is very unusual and can go unnoticed, but we must keep this clinical suspicion in mind. This complication can appear in the transabdominal approach to inguinal hernias; however, it does not occur with an extraperitoneal approach (TEP).

The use of the laparoscopic approach for repair of incarcerated/incisional hernias is increasing, as it is a safe technique with the advantages of being a minimally invasive surgery.