Peer Review File

Article information: https://dx.doi.org/10.21037/dmr-22-8

Reviewer Comments

Dear Editor,

We would like to thank the reviewers and the Editor for the time and the effort they put in reviewing our work and providing us with valuable comments and remarks. We provided pinpoint responses to each reviewer and editor in chief comments and remarks as detailed below, and the paper was changed accordingly.

We feel the paper contains important information for the reader of your journal and, thus, we hope sincerely that updated version of the paper fits with the requirements of your journal.

Reviewer Comments

Comment 1: Dr. Castaldi, et al. reviewed how to manage aberrant RHA in the patients undergoing MIPD. The paper well documented the issues to be cared before and during surgery cumulatively.

I have a few concerns as below.

1. The authors described the difference of "accessory" and "replaced" RHA. The definition of "aberrant" RHA in relation with accessory and replaced RHA should also be described.

Reply1: The difference is added in the introduction:

"An aberrant hepatic artery can be accessory or replaced (6).An accessory hepatic artery (aHA) is a vessel that arises from an uncommon origin and supplies a portion of the liver along with another hepatic artery. The embolization or surgical ligation of an aHA may have no consequence on the vascular supply to the liver.

A replaced hepatic artery (rHA) is a vessel that arises from an anomalous origin and supplies a portion of the liver, that is not supllyed otherwise by any other artery. A careful evaluation before surgery is mandatory to identify this vascular variant in order to avoid any postoperative complications."

Comment 2: The main concern regarding aberrant RHA would be whether we should consider laparotomy for reconstruction when the artery was involved with the tumor. Adding a figure with a kind of flow chart showing the factors to be considered to decide the indication of reconstruction such as the existence of arterial communication or

arterial diameter would be helpful.
Reply 2: A flow chart with a figure is added in the Key factors for a safe MIPD
Figure 1 is added to the paper.

Comment 3: Do the authors consider preoperative angiography with balloon occlusion test to evaluate the communication should be routinely performed especially when the communication could not be clearly demonstrated by CT?
Reply 3: Instead of the balloon occlusion test, we utilize a preoperative angiography with selective catheterization and, also, an intraoperative clamp test with an intraoperative doppler ultrasound to evaluate the liver arterial flow.