

## Peer Review File

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### Reviewer A

The manuscript is well-written and informative.

Reply: Thank you for the comments

Changes in the text: N/A

### Reviewer B

Comment 1: Given the title of the commentary "Is open pancreatic surgery still relevant now in the era of minimally invasive pancreatic surgery?", I would appreciate some more attention in the commentary to the role of open pancreatic surgery e.g., when vascular resection and reconstruction is anticipated - this is still the standard of care internationally despite certain extremely high volume and high expertise centers performing minimally invasive vascular resection and reconstruction. Furthermore, when additional multivisceral resection is anticipated - such as locally advanced pancreatic tumour involving the colon open surgery should remain the standard of care.

Reply 1: Thank you for the suggestion and the important comment. We have included more to discuss about the role of open pancreatic surgery as per your suggestion. Changes are made in red colored text throughout the manuscript.

Changes in the text: We have included this from page 4 line 20 to page 5 line 19: “**This is compounded by the need to overcome the initial LC of MIPS, as well as patients with more advanced disease with invasion into surrounding structures (e.g. borderline resectable pancreatic cancer (BRPC) requiring vascular resection and reconstruction). The International Study Group of Pancreatic Surgery (ISGPS) in 2014 recommends for porto-mesenteric venous resection in patients with BRPC (8). However, literature is even more limited on the safety and oncological outcomes following LPD with venous resection and reconstruction; Ma et al. demonstrated good outcomes following LPD (n=25) with major vascular resection and reconstruction, with lower intra-operative blood loss (200ml vs 400ml, p<0.001) and shorter length of stay (11 days vs 11 days, p=0.005) compared to open pancreaticoduodenectomy (n=38) (9). Additionally, there was no significant difference in post-operative morbidity (grade B or C post-operative pancreatic fistula, delayed gastric emptying, abdominal infection, bile leak, or pancreatic haemorrhage) and oncological outcomes (R0 resection rate and number of lymph nodes harvested). While the results shown by this study is optimistic and promising, LPD with vascular resection and reconstruction is technically challenging and should only be performed in high-volume and experienced surgeons. Similarly, for locally advanced pancreatic cancer with invasion into adjacent structures e.g. colon requiring multivisceral resection (MVR), there is still too little that is known. Laparoscopic MVR has only been shown to have acceptable oncological outcomes with good safety profile in patients with primary colonic or gastric cancer (10). Before any work is done to evaluate the role of MIPS in more extended resections, more**

studies are required to determine the short-term and long-term oncological benefits in standard pancreatic resections for pancreatic cancer first. OPS should still be the standard surgical approach for complex pancreatic surgeries requiring extended resections.”

Comment 2: One aspect that may be useful to add regarding the learning curve is that of "pancreas-adjacent" operations (DOI: 10.1097/SLA.0000000000004432) i.e., other non-pancreas operations may contribute to proficiency in pancreatic surgery.

Reply 2: Thank you for this suggestion and we have looked into the reference. This is an interesting study and we have included this in our discussion.

Changes in the text: We have included this from page 7 line 21 to page 8 line 4: “Interestingly, a recent study found that experience in pancreaticoduodenectomy (PD) is not necessarily essential in achieving good post-operative outcomes (15). Centres with low volume in PD (<11 operations/year) but had high volume in gastric, hepatic, complex biliary or pancreatic operations other than PD (defined as >33 operations/year) did not have increased 30-day mortality (OR 1.258, 95% confidence interval (CI): 0.942-1.680, p=0.1203) or positive resection margins (OR 1.073, 95% CI: 0.948-1.214, p=0.2648). Future consensus statements may also consider the experience in pancreatic-adjacent operations on the recommendations on whether MIPS should be performed, even at low volume centers for pancreatic surgery.”