

## Peer Review File

**Article information:** <http://dx.doi.org/10.21037/gs-20-670>.

### Reviewer A:

#### Comment 1:

The authors performed a matched pair analysis using a large number of patient data from their high volume center to verify the clinical implication of total pancreatectomy in patients with highly risky remnant pancreas comparing to pancreaticoduodenectomy. Their basic procedures to reconstruct the remnant pancreas employed conventional two-layer pancreatico-jejunostomy without any external or internal duct drainage, despite the potentially huge risk of pancreatic fistula in the remnant pancreas.

I can finally agree with the authors' claims as reviewer, however would not understand that they would prefer to a total pancreatectomy without such efforts to reduce complications by adopting another reconstruction method as modified blumgart anastomosis, pancreatic drainage, two-staged pancreaticojejunostomy, etc.

#### Major comment

The author had better discuss the above mentioned items with emphasis on the method of other pancreatic reconstruction.

#### Reply 1:

We are grateful to the reviewer for his constructive criticism. Indeed, all patients who underwent PD within the study period 2009-2018 had a double layer duct-to-mucosa PJ. This was then and continues to be now our standard method of reconstruction and we apply it for all type of pancreata, even in the high-risk patients. This is at least partially due to our early experience before 2009 – we had tried a variety of PJ- techniques, including internal and external stenting, sealing with glues and teres patch, pancreatogastrostomy, telescope and Blumgart methods. However, in our own experience, none of these techniques really proved to be more successful than the double-layered duct-to-mucosa PJ. We participated in several multicenter trials, including the RecoPanc study, and initiated own trials, which were also not able to prove one technique being superior to others. Literature data on all methods of pancreatic reconstruction after PD are still controversial. We believe that the mastery of certain technique is much more important than the type of reconstruction itself.

However, based on our experience with high-risk pancreatic remnant, our team recognised that TP is quite an aggressive option and we continue to seek for alternatives. In the last years we've gathered experience with a modified single-loop reconstruction for PD, use of T-drain to separate bile from pancreatic juice and other methods and selectively covering the hepatic artery with a falciform patch. Recently, we've begun to splint the PJ with a new generation resorbable cellulose stents as a part of a prospective study. Some of these measures show promising initial results.

However, larger collectives of patients are need to allow definitive conclusions about their efficacy and safety.

**Changes in the text:**

In agreement with the recommendation of the reviewer, we added an extensive paragraph on the role of different methods of pancreatic reconstruction and measures to secure the PJ at the end of the discussion section (*see pages 14-15, lines 346-375 and lines 381-383*). Respectively, four references have been added (*see pages 20-21, lines 513-525*).

**Comment 2:**

**Minor comments**

Page 8, lines 3-. Did these postoperative hospital stay (days, in table 2) include those of patients who required re-operation? Mention clearly the relation of postoperative hospital stays between table 2 and 3.

**Reply 2:**

The ICU- and total postoperative hospital stays in table 2 refer to the whole cohort of 100 patients in each group, including those who underwent re-operations.

Table 3 includes data regarding only re-operated patients. This table underwent major revision – in order to avoid misunderstandings, median and interquartile ranges are now represented and p-values for the comparison between both subgroups are added in a separate column. Some mistakes were found in the table and these are now fixed.

Statistically, both ICU- and total postoperative stay were significantly longer for reoperated patients compared to the entire cohort – this information is now included in the results section of the manuscript. The subgroups of reoperated patients were too small to find any significant differences in the hospital stay between TP and PD collectives.

**Changes in the text:**

Additional information about values is given in the legends of Tables 2 and 3 (*see pages 23-24, lines 572-573 and lines 593-597*)

Additional information about the relation between postoperative hospital stays of TP and PD patients of the entire cohort as well as those who were reopertaed is now given in the results section of the manuscript (*see page 9, lines 215-218*)

**Comment 3:**

Page 9, lines 11 and 13. Did MOV mean multiorgan failure? If so, it had better be commonly abbreviated to “MOF”.

**Reply 3:**

Thank you for the correction! We really meant MOF, but got lost in translation and erroneously left the German abbreviation. Now, MOF is correctly used in the revised version.

**Changes in the text:**

Abbreviation changed from MOV to MOF twice (*see page 9, lines 230 and 232*).

**Reviewer B:**

**Comment 1:**

I think that two first paragraphs of methods are results. Numbers of PD and PT and so on, please move to results section.

**Reply 1:**

We agree with the reviewer that the information about the numbers of patients who underwent surgery and those of them who were finally included in the study actually belongs to the results section.

**Changes in the text:**

We moved the information about the numbers of included patients to the results section (*see page 7, lines 166-179*).

Only pure methodological information remained in the methods section (*see page 5, lines 119-126*).