

Peer Review File

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Reviewer A

This is a very interesting paper on locally advanced gastric cancer surgery. The robotic series is very interesting and I want to congratulate the authors for their efforts to promote robotic surgery. However, I have numerous concerns:

1. My major concern is regarding manuscript organization and data presentation. Clearly, the most interesting part of your article is the robotic series experience. You should emphasize on this. At its current form, the paper compares a robotic and an open approach and the conclusion is that robotic surgery for LAGC is great. It is obvious that robotic surgery for LAGC is better!!! We know already (as you state in your discussion) that laparoscopic surgery outcomes for LAGC are far better than those after open surgery and there are already series comparing lap and robotic surgery for this matter. So, it is obvious that robotic surgery will be better. Therefore, in its current form, your paper adds nothing new to the literature and it should not be published. However, if you completely reorganize your paper by describing your robotic surgery experience and data as the center of your paper, providing a paragraph and a few tables on comparing your series with your open experience (stating that you passed directly from open to robotic LAGC surgery, which is great!!!) and with a title like “Robotic gastrectomy for gastric cancer: single Western center results”, I believe that your paper will have great chances to be accepted.

Reply: Thank you very much for your valuable comments and suggestions we agree with you and we have made the appropriate modifications in the structure and content of the manuscript focusing more on the robotic series, our institutional experience, and the short-term outcomes of adoption of this procedure vs the standard of care open for the treatment of LAGC.

Changes in the text: We modify our title to reflect our institutional robotic experience. See Page 1, line 1 and 2. We included a figure demonstrating the transition and adoption through the years from open to robotic surgery for the treatment of LAGC (please see figure 2), see page 12, lines 294-295. We also included a more detailed surgical description of robotic D2 gastrectomy for LAGC, see page 7 and 8, lines 162-182, as well in the discussion see page 14, lines 334-340.

2. Your introduction is nice and smooth. However, lines 112 to 120 (“Robotic-assisted...hospital utilization.”) do not belong to the Introduction section.

Reply: Agree, we removed them and incorporate a better paragraph.

Changes in Text: See page 4 and 5 lines 107-114.

3. What is the aim of your study? It should be clearly stated at the end of your introduction.

Reply: Agree, we included a clear aim at the end of the introduction.

Changes in Text: See page 4 and 5 lines 110-112.

4. Describe more in detail the robotic procedure. It is extremely interesting to provide to us your surgical experience on this hot topic.

Reply: We added a more detailed description, and we referenced our previously published video technique description.

Changes in Text: See page 7 and 8, lines 162-182.

5. 65 references for an original study are too many. Limit to 40 please.

Reply: Agree, we had an initial table 1 that included a literature review with the definition of LAGC which included 24 extra references in this table, we moved this table as a supplement of the manuscript resulting in 43 references.

Changes in Text: See page 19 and 23, lines 433-617.

To conclude, I truly believe that your data are interesting regarding robotic surgery and your experience with it can be beneficial to readers. I hope that you will be able to provide the required modifications to see your work finally published.

Reviewer B

In the manuscript by Rodriguez MJ, et al, the authors have retrospectively analyzed the difference in narcotic consumption, oncologic efficacy, cumulative morbidity, and 90-day resource utilization between 55 patients who underwent standard of care (SOC) and 32 patients who underwent neoadjuvant chemotherapy (NAC) and robotic D2-gastrectomy (RG) for locally-advanced gastric cancer (LAGC) at their institution. Although four domains of treatment burden were significantly reduced in the NAC+RG cohort compared to SOC, the number of patients was too small to conclude that NAC+RG contributed to decreased treatment burden relative to SOC for LAGC. In addition, perioperative patient care, NAC regimens and surgical techniques should have developed during the study period over 10 years, there could be significant bias in this retrospective study comparing two patient cohorts who underwent surgery in the different periods.

Reply: Thank you very much for your comments, we address the limitation of being a small cohort due to the presentation of a single US western center. However, cohorts were well-matched in terms of their baseline demographics and tumor characteristics were validated by central radiology review. Despite the potential for unmeasured confounding and selection bias due to differences in time periods, the quasi-experimental features of an interrupted time series allow to equilibrate known risk factors and evaluate the effect of introducing an intervention in this case robotic surgery to a prospectively maintained database such as this one. Finally, outcomes were analyzed according to intention to treat, including conversion of robotic cases (n=2) and adjusted for variables widely available to other cancer centers who are considering adoption of robotic surgery.