

Peer Review File

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Reviewer A

Uniportal VATS was performed to diagnose small lung nodules in a patient with pancreatic cancer, and a dual-wavelength diode laser was used to resect one of the two lesions. The authors described that the approach allowed for safe and precise parenchyma-sparing resection of a lung nodule, thereby enabling sufficient sealing of the lung tissue. I agree that lasers may be useful for dissecting the lung parenchyma, however; it is questionable whether this method will become widely used as a reliable method of removing such small deep-located nodules.

Major comments

1. It is very difficult to identify a small deep-located nodule after resecting a superficial nodule with an endostapler. It is expected that the deep-located lesion was difficult to identify by palpation. How did you identify the lesion? And how did you confirm that it was the nodule which had been identified by CT?

Thank you very much for this very important comment. The lesion was deep-located in the lung parenchyma, however, it was located close to the horizontal fissure. After mobilization of the fissure, we were able to locate and palpate the lesion. This aspect was added to the revised manuscript (see page 4, lines 79 – 82). Moreover, further CT-scan images were added to figure 1 to illustrate the exact position of the suspect lesion.

2. It is advisable to present a macroscopic finding of the resected specimen to show that the lesion has been resected with sufficient margin.

Thank you very much for this valuable recommendation. Unfortunately, we did not take picture of the resected specimen. After resecting the specimen we investigated it macroscopically and sufficient resection margins were confirmed. This was added to the revised manuscript (see page 4, lines 85 – 86)

Minor comments

1. Why did you use Gel point? It might make sense if you had connected a smoke evacuator.

Thank you very much for your question. When routinely performing subcostal VATS we only utilize an Alexis O wound retractor. However, when laser application is planned, we use a Gel point system to enable a precise insertion and utilization of the laser probe, thereby minimalizing larger movements while applying the laser. Carbon dioxide insufflation was not used. This was mentioned in the revised manuscript (see page 4, lines 74 – 76).

2. Line 76-77: a further lesion was identified close to the horizontal fissure and a pulmonary artery branch (Fig. 3). Is it Fig. 1? If so, the nodule is close to a pulmonary vein, not pulmonary artery.

Thank you very much for your valuable comment. We have corrected this mistake in the revised manuscript (see page 4, lines 80 – 82)

3. “Transthoracic uniportal VATS” is an unusual word.

Thank you very much for your comment. We have replaced the term “transthoracic uniportal VATS” by “conventional uniportal VATS”

Reviewer B

The points of emphasis in this case report are the uniportal technique, sub-costal approach, and the use of a newer generation dual-wavelength diode laser. The most important among these is the tumor enucleation using a laser device to resect and seal the lung tissue without damaging the parenchyma; the sub-costal and uniportal aspects of the surgery are less important in this case.

Please describe the mechanism and effectiveness of this device in detail since only a few institutes perform tumor resection using an intraoperative laser device.

Please consider adding the following points:

1. Why did you use GelPOINT as the access device? Did you also resect the tumor using carbon dioxide insufflation?

Thank you very much for your question. When routinely performing subcostal VATS we only utilize an Alexis O wound retractor. However, when laser application is planned, we use a Gel point system to enable a precise insertion and utilization of the laser probe, thereby minimalizing larger movements while applying the laser. Carbon dioxide insufflation was not used. This was mentioned in the revised manuscript (see page 4, lines 74 – 76).

2. On L77, isn't this Figure 1? Please indicate the lesion with an arrow in Figure 1.

Thank you very much for your valuable comment. It is Figure 1 and not 3. This was corrected in the revised manuscript. Moreover, further CT-scan images and arrows were added to figure 1 to illustrate the exact position of the suspect lesion.