

Peer Review File

Article Information: <https://dx.doi.org/10.21037/tau-23-54>

Reviewer A

Would you please explain how the size of the remnant adrenal gland tissue was measured?

Reply: We estimated the percentage of the remnant adrenal gland tissue by two parts: part 1) estimated the total size of the adrenal gland tissue by CT before operation; part 2) estimated the size of the isolated adrenal tumor with little normal adrenal tissue which removed from body. Then, the estimated percentage of adrenal preserved was got by part 1 to subtract part 2.

Changes in the text: add “The estimated percentage of adrenal preserved was measured by estimating the total size of the adrenal gland tissue by CT before operation to subtract the estimated size of the isolated adrenal tumor with little normal adrenal tissue which removed from body.” to Line 147.

Did you consider using for intraoperative navigation (to define the correct plane for enucleation and the characteristics of the tumor, vascularization and the size of the remnant tissue) intraoperative laparoscopic ultrasound?

Reply: Thanks for your question. Usually, intraoperative laparoscopic ultrasound was not needed for the enucleation adrenalectomy. The main reason was that the enucleation performed after the tumor was clearly exposed which the whole adrenal tumor and adrenal vein was carefully mobilized. In that way, we can clearly define the correct plane for enucleation.

However, for the tumor which the location of adrenal tissue hardly to clear expose (especially for the tumor in the right adrenal limb which closed to the liver). The intraoperative laparoscopic ultrasound was useful to define the correct plane for enucleation, vascularization and the size of the remnant tissue.

Changes in the text: add “The intraoperative retroperitoneoscopic ultrasound was selected used to define the correct plane for enucleation in this process” to Line 133.

Line 73-are the potential malignancies an inclusion criterion?

Reply: Thanks for your advice.

Changes in the text: Line 88-89“3) the low potential malignancies were discovered”

Would you please explain if in every operation the enucleation was possible without defragmentation of the tumor and if in every case the resection was complete?

Reply: Thanks for your question. In general, the resection was complete in all cases. However, the defragmentation of the tumor in the blunt dissection while enucleation process was happened in four cases. The information about “tumor defragmentation” and “resection incomplete” was added in Table 1.

Changes in Table 1: The information about “tumor defragmentation” and “resection incomplete” was added in Table 1.

Would you please explain the possible scenario and recommendations if, in the postoperative histopathology, the cancer is found?

Reply: Thanks for your advice. Although, the incidences of cancer in this study would be very low by the patient selection and preoperative assessment (according to the imaging characteristics listed by ACCE/AAES guidelines). We have two recommendations when cancer was encountered:

1) if the tumor was suspected to be cancer after enucleation (the intraoperative frozen section of the isolated adrenal tumor which removed from body was suspected cancer), immediately salvage total adnectomy before anesthesia recovery would be performed. 2) when cancer was found by pathology after surgery, salvage total adnectomy would be performed within two weeks.

Is a prior operation a disadvantage if the reoperation is indicated?

Reply: Thanks for your question. In our opinion, there was a disadvantage if the duration of the reoperation time longer than 2 weeks, which increasing operative difficulty and complications. Therefore, when cancer was found by pathology after surgery, salvage total adnectomy would have been performed better within 2 weeks.

Changes in the text: Add “In our opinion, once the tumor was suspected to be cancer after enucleation (the intraoperative frozen section of the isolated adrenal tumor which removed from body was suspected cancer), immediately salvage total adnectomy before anesthesia recovery would have been performed. Meanwhile, when cancer was found by pathology after surgery, salvage total adnectomy would have been performed better within 2 weeks.” to Line 232-237.

In Table 1-Conversion to laparoscopic total adnectomy than only Conversion would be better.

Reply: Thanks for your advice.

Changes in Table 1: change “Conversion” to “Conversion to laparoscopic total adnectomy”.

Postoperative length in hospital stay, days would be better than Postoperative length in hospital, d

Reply: Thanks for your advice.

Changes in Table 1: change “d” to “days”

Reviewer B

1. Laparoscopy and retroperitoneoscopy are not the same technique. The first includes access to the peritoneal cavity, which the second does not. They cannot be used this way.

Reply: Thanks for your comments and advising.

Changes in the text: Some “laparoscopy” has been changed to “retroperitoneoscopy” in the revised manuscript.

2. Regarding limitations of the study, it would include the absence of a statistical analysis, since what is expressed is only a description of the data. A comparative analysis would be necessary with the results and their complications, compared with the follow-up, to know if their conclusions are completely true.

Reply: Thanks for your suggestion. We added the absence of a statistical analysis in the study and a comparative analysis would be necessary in the further study Line288

Changes in the text: Line 288-291 “Inherent limitations of the current study include the retrospective nature of the study, the absence of a statistical analysis and the small sample size. Furthermore, a prospective randomized controlled study is needed to compare the clinical efficacy and complications of enucleation therapy relative to total adrenalectomy.”