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Peer Review File

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Reviewer A

I congratulate the authors for their nice case report and innovative approach for autologous breast reconstruction by local/regional perforator flaps combination. I trust this case report would be of interest to the reader of the ABS. I disagree though with how it was presented as a substitute to other free flaps owing to less donor site morbidity, unsightly scars, etc (e.g. lines 66-68, 102,234,235). Also, the references quoted to support such observations are a bit dated e.g. references numbers 1-12.
Best wishes

Comment 1: I disagree though with how it was presented as a substitute to other free flaps owing to less donor site morbidity, unsightly scars, etc (e.g. lines 66-68, 102,234,235).
Reply 1: Thank you very much for your feedback. The discussion section has been amended to suggest that stacked perforator flaps are an alternative to consider apart from other free flaps.
Changes in the text: Page 10, lines 242 to 243.

Comment 2: Also, the references quoted to support such observations are a bit dated e.g. references numbers 1-12.
Reply 2: The references have been amended to include recent studies within the past 5 years.
Changes in the text: Page 13, lines 342 to 345.

Reviewer B

The authors describe stacked intercostal perforator flap surgery performed due to optimal anatomy and fat distribution in the patient which allowed two pedicled flaps to be harvested in the intercostal region. Overall, this is a well-written paper and has introduced a technique that other surgeons may consider while operating on their own patients.

Suggested changes are:
1. The abstract needs to be reworded and consolidated to emphasize more on the flap technique.

2. Figure legends-these should be much shorter, the largest dimension of the mass can be mentioned and please mark all the imaging features with different types of arrows/circles/stars. Current markings are not well visible.
3. Discussion: Please describe the 'morbidity' associated with free flap surgeries.
4. Please include any unique complications associated with intercostal flaps in the discussion.

Comment 1: The abstract needs to be reworded and consolidated to emphasize more on the flap technique.
Reply 1: Thank you very much for the feedback. The abstract has been amended to place more emphasis on the flap technique.
Changes in the text: Page 2, lines 38 to 53.

Comment 2: Figure legends-these should be much shorter, the largest dimension of the mass can be mentioned and please mark all the imaging features with different types of arrows/circles/stars. Current markings are not well visible.
Reply 2: The legends have been made more concise. The imaging features have been marked out.
Changes in the text: Figures 1 (page 5) and 3 (page 8) have been amended.

Comment 3: Discussion: Please describe the 'morbidity' associated with free flap surgeries.
Reply 3: Potential morbidities associated with free flaps have been included in discussion.
Changes in the text: Page 10, lines 235 to 239.

Comment 4: Please include any unique complications associated with intercostal flaps in the discussion.
Reply 4: Complications associated with intercostal flaps have been included in the discussion.
Changes in the text: Page 11, lines 281 to 285.

Reviewer C

Thanks for asking me to read this paper where the authors present a case of total breast reconstruction with stacked local flaps.
The technique has a good potential and definitively should be considered among the possibility in breast reconstruction.

I've some advices that may improve the quality of this article:
• In the introduction paragraph the authors state that the donor sites for autologous

reconstruction are the abdomen and the latissimus dorsi only, that is a wrong statement. Nowadays there are several donor sites available for flaps. (thighs, lumbar area, buttocks and so on).
• The oncological patient story is well described but too many details are reported taking off the attention from the main topic of the paper: the reconstruction. I would reduce this session, maybe summarising it in a table, Figure 1 can be removed.
• Improve the flap harvesting description: isolation of the perforators, their dissection up to what? Fascia, origin… add this to the case report removing the narrative description of intercostal flap form the discussion paragraph.
• Focus more the discussion on pro e cons of this procedure, discuss the limits in detail, indications and contraindication have to be discussed as well.
• My concern is related to the mastectomy flap that can be devascularized by the extensive access (the entire IMF extended laterally). More cases should be done to prove if this procedure is safe.
• Regarding the cosmetic outcome, I think this technique provides a good breast mound although the symmetry with the contralateral breast hasn't been achieved.
• The mobilization of those flaps creates an asymmetry in the upper abdominal area and lateral aspect of patient's chest, this in a younger patient would reduce patient satisfaction.

Comment 1: In the introduction paragraph the authors state that the donor sites for autologous reconstruction are the abdomen and the latissimus dorsi only, that is a wrong statement. Nowadays there are several donor sites available for flaps. (thighs, lumbar area, buttocks and so on).
Reply 1: Thank you very much for the feedback. Other donor sites available for flaps have been included in the introduction
Changes in the text: Page 3, lines 67 to 68.

Comment 2: The oncological patient story is well described but too many details are reported taking off the attention from the main topic of the paper: the reconstruction. I would reduce this session, maybe summarising it in a table, Figure 1 can be removed.
Reply 2: A greater focus is placed on the reconstruction and patient's history has been made more concise.
Changes in the text: Page 3 to 7, lines 83 to 181.

Comment 3: Improve the flap harvesting description: isolation of the perforators, their dissection up to what? Fascia, origin… add this to the case report removing the narrative description of intercostal flap form the discussion paragraph.
Reply 3: A more detailed description of the flap harvesting process has been included.
Changes in the text: Page 7, lines 161 to 178.

Comment 4: Focus more the discussion on pro and cons of this procedure, discuss the limits in detail, indications and contraindication have to be discussed as well.
Reply 4: Further elaboration on the pros, cons, indications and contraindications of this approach has been included in discussion.
Changes in the text: Page 10 to 11, lines 241 to 269.

Comment 5: My concern is related to the mastectomy flap that can be devascularized by the extensive access (the entire IMF extended laterally). More cases should be done to prove if this procedure is safe.
Reply 5: We acknowledge that our case report only includes a single patient and may submit a case series as more cases are performed at our centre as highlighted at the end of the discussion.
Changes in the text: Page 12, lines 298 to 300.

Comment 6: Regarding the cosmetic outcome I think this technique provides a good breast mound although the symmetry with the contralateral breast hasn't been achieved. The mobilization of those flaps creates an asymmetry in the upper abdominal area and lateral aspect of patient's chest, this in a younger patient would reduce patient satisfaction.
Reply 6: We acknowledge that this technique described may produce some asymmetry with the contralateral breast and in the upper abdominal area. These limitations have been highlighted in the discussion.
Changes in the text: Page 12, lines 295 to 303.

Comment 7: This technique is promising, but a case series is recommended to provide more evidence regarding the procedure.
Reply 7: Thank you for the feedback. As more cases are performed at our center, we may submit a case series in the future as highlighted at the end of the discussion.
Changes in the text: Page 12, lines 298 to 300.