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Peer Review File

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Response to the Reviewer A

Dear reviewer A,

We appreciate your comments on our manuscript. Our replies to your comments are as follows.

Comment 1:

Please provided abstract in the format of the journal. Rephrase the aim by for example: A review of the literature was performed and our standard laparoscopic RAMPS technique was described.

Reply 1:

We appreciate your pointing out our inadequate formatting of the abstract. We have added some sentences in the abstract and have added the phrase indicating the aim you provided (see page 3 to 4, Abstract).

Changes in the text:

However, it is technically demanding, and a lack of experience can lead to serious intraoperative and postoperative complications or local recurrence due to residual tumors at the surgical margins (lines 4 – 6 on page 3). Preoperative evaluation should be focused not only on the tumor characteristics but also on the anatomical variations of major vessels (lines 8 – 9 on page 3). Retracting the liver and stomach is crucial for obtaining appropriate operative fields around the pancreas. Optimizing the caudal view of laparoscopy is important for safe approaches to the major vessels. Adequate posterior dissection according to the extent of retropancreatic invasion and en bloc regional lymphadenectomy should be performed for oncological benefits. Additionally, proper pancreatic transection with precompression of the pancreas, adequate selection of the cartridge of stapler, and slow firing technique is crucial for the prevention of postoperative pancreatic fistulas. A review of the literature was performed and our standard L-RAMPS technique was described (from line 11 on page 3 to line 1 on page 4).

Comment 2:
Line 55:rephrase: ‘g a negative retro-pancreatic margin’ (remove of PDAC)

Reply 2:
We appreciate your giving us the suggestion of rephrase. We have removed ‘of PDAC’ (see line 10 on page 5).

Changes in the text:
It has been reported to be useful for obtaining a negative retro-pancreatic margin ~~of PDAC~~ (4,5), possibly reducing local recurrence (6).

Comment 3:
Line 60: rephrase to ‘the possibility for 3d-vision’ since not all centers have this 3d laparoscopy available

Reply 3:
We appreciate your giving us the suggestion of rephrase. We have rephrased the sentence (see lines 14 - 15 on page 5).

Changes in the text:
The advantages of L-RAMPS include the magnified view of laparoscopy possibly with three-dimensional imaging system,

Comment 4:
Line 64 and 65: please explain anterior and posterior RAMPS further for less experienced readers

Reply 4:
We appreciate your comment on the necessity to explain anterior and posterior RAMPS. We have added a sentence to explain the difference between them (see lines 2 - 3 on page 6).

Changes in the text:

The difference between these operations is whether to resect the left adrenal gland.

Comment 5:
Line 67 – 68 please rephrase the aim according to suggested in the abstract

Reply 5:
We appreciate your giving us the suggestion of rephrase. We have rephrased the aim (see lines 5 - 6 on page 6).

Changes in the text:
A review of the literature was performed and our standard L-RAMPS technique was described.

Comment 6:
Line 75-76 please explain more why you think that a tumor in 5mm distance to the origin of the splenic vessels should be a contra-indication?

Reply 6:
We appreciate your giving us the suggestion of explanation for it. We have rephrased the sentence to explain the reason (see lines 12 - 15 on page 6).

Changes in the text:
Although invasion of the splenic vessels is not a contraindication, a distance of less than 5 mm between the tumor and the origin of the splenic artery (SpA) should be a contraindication for L-RAMPS as a safe ligation and division of the SpA is difficult.

Response to the Reviewer B

The authors offer a detailed methodological description of their way of performing laparoscopic RAMPS, primarily published as “open RAMPS” by Strasberg 2003 (ref 3). Merely surgical details are focused, combined with numerous contentioins, some of

them wrong, ex: p 10, line 158: “Encircling the CHA is crucial for the safe pancreatic transection at the neck”. At our center, having practiced laparoscopic distal resection as standard of care for PDAC during more than 25 years, this is not recommended, and our low complication rates are published.

The value of the paper might be good illustrations and some of the specific surgical “tips” – some are applicable. However, this is in my view a paper coming too late. As a guideline at a local hospital, this method might be fine, but it is completely invalid in an international setting.

Reply: We appreciate your review and comments on our manuscript. We routinely encircle the CHA to secure it, but understand some institutions do not. We have rephrased the sentence (line 6 on page 11) as below.

Changes in the text:
Before transecting the pancreas at the neck, we routinely encircle the CHA.