Peer Review File

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Reviewer A

Comment 1: Overall, the manuscript is well written and addresses the problems of pancreatic anastomosis in high risk settings well.

Reply 1: We are grateful to Reviewer A for dedicating time to review our manuscript and appreciate their positive and encouraging comment. Changes in the text: None.

Reviewer B

Comment 2: Minor changes needed eg the acronym PAC - what does this stand for? It was not explained in the paper.

Reply 2: We thank Reviewer B for thoroughly reviewing our manuscript and pinpointing inconsistencies. The acronym the reviewer refers to is in fact a typographic error, it should be "PA", which has been referred at the beginning of the same paragraph. Changes in the text: Replaced the two instance of "PAC" by "PA" in the first paragraph of the introduction.

Comment 3: One question to ask is - this paper is meant to be for minimally invasive pancreatoduodenectomy. But the steps given here could easily be used in open pancreatoduodenectomy too. Any reason why it was written specifically for minimally invasive PD?

Reply 3: The reviewer is correctly pointing that these techniques are also applicable to open surgery. We have focused our manuscript around their application in minimally invasive surgery precisely to highlight that MIPD is a very valid option surgeons should strongly consider even in the complex cases presented here and the technical challenges involved. This comment has inspired us to add a clarifying note in the manuscripts abstract. Changes in the text: We have included a sentence before the end of the abstract acknowledging the applicability of our suggestions to the open surgery setting and stating our educational purpose towards MIPD.

Comment 4: Otherwise, the paper is written in a succinct manner - appropriate for the category of publication. Table 1 is the key figure which summarises the whole article nicely.

Reply 4: We appreciate the reviewer's positive comment towards our work.

Reviewer C:

Comment 5: Nice summary of PJ MIS approaches. Several small comments: 1. Spell out all abbreviations. Assuming CPRE is endoscopic retrograde cholangiopancreatography. Reply 5: The reviewer is right in that we had not properly spelled out all the acronyms and abbreviations throughout the text in the original manuscript. We have now thoroughly reviewed and spelled out all the acronyms.

Changes in the text: 1) We have replaced CPRE by endoscopic retrograde cholangiopancreatography (ERCP)

Comment 6: 2. For total pancreatectomy, need to mention caveat of brittle diabetes, which requires a reliable patient and excellent endocrine ancillary services for good control.

Reply 6: The reviewer is indeed right in pointing at brittle diabetes as a very important comorbidity following total pancreatectomy. Total pancreatectomy should be avaoided to the extent possible, and we now make an explicit mention about it in the manuscript. Note also that, in the main text we also mention some interesting experimental treatments as alternatives to totalization. Theseshow encouraging results. The works with endoductal radiofrecuency ablation in particular have the potential to become a good alternative, in the complex cases discussed, to the totalization, as they seem to preserve the islets of Langerhans, and consequently the endocrine function.

Changes in the text: We have now included a new sentence in the second paragraph of the section “Acute pancreatitis of pancreatic stump” (“It is important…”). We have also added a second sentence at the end of the section “Failure of previously performed pancreatic anastomosis” (“The latter approach…”).

Comment 7: 3. Typo: "Burdio et al. (17) have shown encouraging results with radiofrequency ablation of the main 89 pancreatic duct in case of failure of PA, in both scenarios, during surgery o during reoperation.”

Reply 7: We thank again the reviewer for pointing out parts of the text that can be improved for readability. We have reviewed the original text and haven’t been able to identify the source of the unwanted characters (i.e., “89”). We are reporting this issue to the editorial team so it can be address on the journal’s end.
Changes in the text: None.

Comment 8: Videos are good. Do the authors only place a single plastic clip on splenic artery stump in video 2? Or is additional suture/clip placed?

Reply 8: We appreciate the positive reviewer’s comment. In regards to the technical question, in this case we only use one hem-o-lock clip. Sometimes we use an additional one or even a suture when the artery presents a largediameter, or even when the risk of POFP is hight. In the case presented in video 2, as we perform a total pancreatectomy, we are safe using a single clip.

Changes in the text: None.