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Peer Review File

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Review Comments

Reviewer A

Line 37: 'covered' in place of 'cover'
Reply: Changed in text

Line 64: '3rd most common esophageal masses'. Please cite. By extension, it will be appropriate to state what the the first two are providing references for same.
Reply: This statement was removed

Line 87: 'dextrorotation' (spelling edit).
Reply: Changed to clockwise rotation

Line 90: the flow is lost in the diagnostic work up/chain. This section will be best served by the authors' institutional diagnostic algorithm (if any) or a standardised sequence of investigations for symptomatic patients.
Reply: This section has been edited

Line 76: what are the most common symptoms based on documented case series?
Are there any available data on the risk of malignant transformation? This is important as this may justify offering resection to asymptomatic patients.
Reply: The symptoms listed in the manuscript are taken from previously published series that did not document the percentages of the presenting symptoms. Unfortunately, resection in asymptomatic patients remains controversial as there are no clear clinical guidelines. Reference #12 documents malignancy within a duplication cyst, however the data for malignant transformation is not well described in the literature.

Line 134: what is your choice of preop antibiotic(s)? Any anaerobic coverage?
Technique described (trans-abdominal) allows for mediastinal dissection up to the level of the inferior pulmonary vein; it will be pertinent as well to briefly describe thoracoscopic (with or without robotic assistance) and cervical approaches to more proximal lesions.
Reply: We usually administer a first generation cephalosporin if the patient does not have any documented allergies.

Lines 177-178: 'obtained' (obtain).
'… translate in reduced risk of mucosal injury, improving surgical outcomes'. This is a fairly categorical statement without sufficient evidence. Studies comparing laparoscopic or thoracoscopic approaches versus robotic techniques have shown similar short and long-term outcomes. The robot with its added degrees of freedom indeed offers better economics and allows for higher mediastinal dissection compared to the laparoscopic technique.
Reply: Corrected.

Reviewer B

The authors present an overview of esophageal duplication cyst and then provide a brief technical description of a surgical case.

I would emphasize the following points: bronchogenic cysts are the most frequent developmental cysts of the foregut. By definition, they may contain any of the histologic components of the bronchi or esophagus, and are most often located in proximity to foregut structures. In practice, then, the distinction between bronchogenic cyst and esophageal duplication is not an easy one. I think that elaborating on this issue would have been helpful, as would have been providing a pathologic description and/or slide of the resected specimen.
Reply: This has been edited.

I would advise caution when discussing surgical indications. Assigning symptoms to such a cyst is not straightforward, and many such benign lesions are incidental findings. I suggest the burden

for establishing a causal relationship between such a cyst, especially if it is small, and any symptoms the patient may have been experiencing rests with the clinician. Also, there is a heavy bias toward the publication of symptomatic or complicated cases, and therefore the admittedly low risk of complications or malignancy likely still represents a substantial overestimation of any actual risk. I would be very circumspect in advocating for the resection of small asymptomatic lesions.

Reply: This has been edited

The authors describe an abdominal robotic approach to an esophageal cyst resection. As a purely technical description it is rather short on detail. The authors do not provide any clinical or preoperative anatomic information about their case, and they do not explain the rationale for their surgical approach, including the rationale for what lesions should be approached form the chest and which ones from the abdomen. Obviously, an abdominal approach results in the disruption of the hiatus and natural antireflux mechanisms and so this must be weighed against the possibility of alternative approaches given the size and location of the lesion. Endosopic resection of esophageal duplication cysts has been described, and I think that interventional endoscopy merits a comment or two.

(Following are the suggestions from Guest Editor about the comments of Reviewer B)

I understand concerns of Reviewer B about type of paper, however it would become more clear when readers see the entire series together. We may need to do some work to make it flow easily from one paper to the next. I think authors did a good job explaining pathological differentiation with bronchogenic cyst. Perhaps they should include a sentence like the reviewer suggests, "the distinction between bronchogenic cyst and esophageal duplication is not an easy one" and explain that only a clear communication with the esophagus (less than 20% of cases) or pathology would establish differentiation. I agree with reviewer about share decision making with patients about risks vs benefit of surgical excision for asymptomatic small cysts. My main interest on this topic is precisely that, no a lot of clear evidence of risks vs benefits (described in another paper in our series).

Reviewer C

It is an interesting review of a rare mediastinal cyst.
It is an uncommon topic and I think is appropriate to publish a review in this journal and go through the main bibliography about it. However, it could be deeper and clarify better some controversial aspects.

I have some comments that I leave below:
- In the Introduction section (Line 62-64) some data are showed supported by very old references. More actualized data would be advisable.
- In the Introduction section (Line 65) the authors could comment which are the first and second most common esophageal mass.
Reply: This has been edited

- Line 87: the reference 16 is cited after the reference 7 and before the references 8-15.
Reply: We have edited and corrected the references, thank you.

- Line 87: the word "dextrotation" is incorrect.
Reply: This has been changed

- Line 114: the reference 19 is cited after the reference 16.
Reply: This has been corrected.

- Line 126: I think figure 3 should be in line 120-121.
- The authors comment in line 128-129 that surgical treatment is indicated in asymptomatic patients because of the risk of future complications and malignant transformation. They repeat this idea in the Summary. I think the authors could clarify why the asymptomatic patients should be operated on and which is the risk of the most important complications such as infection or malignant transformation. The references used to support are 12 and 13. The reference 13 is only about children and the reference 12 presents a case of a patient with an esophageal cancer and a duplication cyst simultaneously detected but the relationship is not clear.

Reply: We have edited the recommendation and emphasized the importance of shared decision making with patients in appropriate operative candidates.

- In the surgical approach section, I think the explanation of the robotic technique of the authors is too large and detailed. Instead of that, it would be more interesting to know which are the advantages and disadvantages of the thoracic and the abdominal approach and in what cases we should choose each approach.

Reviewer D

This is a nice review of esophageal cysts and a good description of a surgical technique of handling a disorder esophageal duplication cyst. I do believe that highlighting your technique with a nice touch for the article.
The images are excellent and really add to the education of the paper.
Nice work.

Reviewer E

I accept the article as it is, now

Reviewer F

Well written article, demonstrates importance for clinicians to make the right steps in diagnostic and treatment of this relatively rare condition.