Peer Review File

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OF NOTE

We decided to remove the supplementary files as these references were already mentioned in the text and are well-known and available from PubMed as well.

REVIEWER COMMENTS

We would like to thank all reviewers for their interest in and critical appraisal of our manuscript.

Reviewer A:

Comment 1: I would like to make a change in the title: Minimally Invasive Ivor Lewis resection with linear stapler anastomosis.

Reply 1: we thank the reviewer for the suggestion to change the title for this study. However, the current title was adapted from the writing template as provided for the Special Series. If the Editor agrees we would suggest changing the title to: "Minimally invasive Ivor-Lewis esophagectomy with linear stapled side-to-side anastomosis"

Comment 2: Trocar (or trocars) instead of trocard (s)

Reply 2: the reviewer pointed out this typo. This was changed in figure legend of Figures 1 (page 21 line 379) and Figure 2 (page 23 line 399)

Comment 3: Please describe the % and treatment that you will adopt for leakage type II.

Reply 3: the reviewer correctly suggests mentioning the % and treatment for type II leaks, as it is more in line with the special series. This information has added to the abstract (page 3 lines 14-18) and the results section (pages 14-15, lines 254-264).

Reviewer B:

Comment 1: One comment from my side: is it not more an end-to-side anastomosis you present as a side-to-side anastomosis?

Reply 1: we thank the reviewer for the interest in our study and commenting on it. We understand this remark when looking at the end result, and in fact the anastomosis is somewhere in between. However, in our opinion the technique of this anastomosis with the linear stapler is a side-to-side technique and not an end-to-side technique and therefore we have termed it in this way.

Reviewer C:

Comment 1: Several methods are known for reconstruction techniques in MIE-IL (linear stapler, circular stapler, hand-sawn, and so on). Authors should mention why they selected linear stapled side-to-side anastomosis, the main subject of this paper, as their routine reconstruction method in “INTRODUCTION” section. Based on this background, the purpose of this retrospective observational study also should be clarified in “INTRODUCTION” section.

Reply 1: we thank the reviewer for pointing this out to us. We agree that the motives for the linear stapler technique should be mentioned in the introduction. We have added this to the introduction section (page 5, lines 40-45). We have further elaborated on this in the discussion section as well (page 16, lines 271-276).

Comment 2: Authors need to discuss merit and demerit of typical reconstruction methods used in MIE-IL in “DISCUSSION” section.

Reply 2: this is an excellent remark by the reviewer and thank the reviewer for pointing this out to us. We have added more discussion on these techniques in the discussion (pages 16-17, lines 283-300).

Comment 3: In “RESULTS” section, the description of patients’ characteristics is not enough. Such data as gender, sex, BMI, TNM stage, percentage of upper mediastinal dissection, and regimen of neoadjuvant chemoradiotherapy should be shown, preferably by adding a new table. Intraoperative blood loss volume is also to be described.

Reply 3: we agree data were lacking and have added Table 1 (page 28) for more baseline characteristics as well as adding a few key elements on this in the results section (page 14, lines 238-247).

Comment 4: In “RESULTS” section Line 238: Which site of side-to-side anastomosis was the leakage point in three patients who required reoperation? This information will be helpful for esophageal surgeons.

Reply 4: the reviewers enquires more clarification on the patients that underwent reoperation due to the anastomotic leak. This is an excellent point as it provides more insight in how the leaks were handled. We have added more details on this in the results section (pages 14-15, lines 257-263).

Comment 5: Because this manuscript is focused on surgical reconstruction technique, description about perioperative management such as ERAS or prehabilitation in “DISCUSSION” section is quite confusing. This reviewer recommend that discussion of this study comprise mostly technical aspects;

tips and important point of their method, comparison between some reconstruction methods (also associating Major Points 1) 2).

Reply 5: we thank the reviewer for this recommendation. Although it may have been confusing, in our opinion it should be mentioned in the discussion. The reason for this is that – although we appreciate the improved outcomes – it may be a potential source of bias if the pre- and postoperative clinical pathways are not well defined when evaluating an anastomotic technique itself. However, we have moved the discussion/paragraph on this topic to the limitation section, so that our motivation for mentioning it is clear. (Page 17, lines 304-309)

Comment 6: Limitation of this study is missing in "DISCUSSION" section.

Reply 6: the limitation section was most likely missed by the reviewer. An explanation for this may be that it was incomplete. In addition to comment 5, we have added more discussion on the strengths and limitations of this study (page 17, lines 301-313)

Minor Points:

1) Line 67-69: Standing position of assistant surgeon and scrub nurse is different between main document and Figure 1.

Reply: we have rectified this in the main text as the positions as shown in Figure 1 are correct (page 7, lines 88-89)

2) Line 69-70: Why camera port is not placed just in umbilicus but above and left side of umbilicus?

Reply: in our experience this provides better laparoscopic vision/exposure and is more ergonomic. We have added this argument in the methods (page 7 lines 92-93)

3) Line 72, etc.: Unit of pneumoperitoneum pressure is cmH2O or mmHg ?

Reply: this should be mmHg and has been corrected (page 7 line 94 and page 10 line 152)

4) Line 74: "the midline" means the middle clavicular line?

Reply: the midline refers to the abdominal midline. This has been added in the main text. (page 7 line 91 and 96)

5) Line 112: The location of the additional port should be depicted in Figure 1.

Reply: a great suggestion by the reviewer. Figure 1 has been updated. Of note, the position of 5 mm port was also moved as it should have been slightly more caudally.

6) Line 144 etc.: Terms “oesophagus” and “esophagus” should be unified.
Reply: an excellent point. We have unified this to esophagus/esophageal in the main text.

7) Line 185: How the secondary V-Loc is sutured is difficult to understand. Additional explanation will be helpful.
Reply: this part was rewritten to clarify how the secondary V-loc is sutured (page 12, lines 196-200)

8) Line 199-203: It is unclear why the intrathoracic pressure needs to be maintained by leaving pleura uncut instead of primary mini-thoracotomy during specimen retrieval.
Reply: this is so that vision is not lost after the intrathoracic pressure drops when the pleura is cut. By maintaining pressure, the 5mm port can be inserted under direct thoracoscopic vision and this makes it easier to grab the endoscopic pouch. This has been clarified in the main text (page 12, lines 214-216)

9) Line 239: What is the definition of anastomotic stricture, endoscopic finding or patients’ symptom?
Reply: this has been added to the definitions. (page 7, lines 74-76)

10) Line 258: “if” is misspelling of “of” ?
Reply: we have rectified this typo (page 16, line 287)

11) Line 359 (Figure 6): Which ports do the operator and the assistant use respectively?
Reply: this information has been added to the figure legend (page 23, lines 399-401)

12) Line 379 (Figure Legend 10): “(held by right grasper)” Right hand of operator or assistant should be clarified.
Reply: this should be the assistant’s right hand and has been clarified. (page 25, line 418)

13) Table 1: What is “Tissue health”? This is not explained in the main document
Reply: the term tissue health referred to the extent of necrotic tissue, which may indicate the leak occurred due to insufficient vascularization of the tissue at the anastomotic site. As this was unclear we have changed this to “extent of tissue necrosis” in Table 2 (page 29)