

Peer Review File

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Reviewer A

Although the number of patients is very small and it is early to say the technique/ device is safe, the journal article is well written, and I appreciate the innovative technique to insert the linear staplers. Thank you for the opportunity to review the article. Please respond to my few questions.

1. Is it possible to use materials already available in OR such as glove-fingers instead of LCSGD?

Reply 1: In fact, this LCSGD is assembled from materials already in the operating room, such as yellow rubber tube is a part of the 16F urinary catheter. As for glove-fingers, we think it is too soft to fix and connect, leading to increased risk of shedding and failure and its diameter does not conform to the linear cutting stapler.

2. How the LCSGD docks to gastric tube? Is the connection strong?

Reply 2: The LCSGD is suitable for the size of the inner diameter of the gastric tube, which can be connected and fixed just by inserting the gastric tube. So far, the connection is very strong, no shedding phenomenon.

3. Page 6, line-158; Is it mesentery or mesangium?

Reply 3: It is mesentery.

Changing in the text: We have modified our text as advised(see page 5 ,line-167).

4. The idea behind totally laparoscopy surgery is to prevent midline incision and mobilization and exteriorization of bowel. Was not it possible for an intracorporeal jejunojejunostomy?

Reply 4: Totally laparoscopic surgery can be performed in vivo jejunum jejunum anastomosis, not the focus of this article, so it is not explained in detail. However, we are accustomed to using the incision of the specimen for extracorporeal jejunal anastomosis, which has the following advantages. First, extracorporeal jejunal anastomosis can speed up the operation and reduce the operation time. Second, jejunal anastomosis in vitro can reduce the time of pneumoperitoneum and reduce the occurrence of hypercapnia. At the same time, liver suspension can be removed to reduce the possibility of liver injury.

5. I would appreciate if authors could show a figurative sketch of how the anastomosis limbs were fixated and overlapped.

Reply 5: The sketch has been put into Figure 2.

6. A short video showing the device use would be helpful for the readers.

Reply 6: we have attached the short video to the email.

7. How do authors ensure sufficient length of the remnant esophagus, especially if the tumor is in cardia? Please mention whether there was difficulty in inserting linear stapler into a short retracting esophageal stump.

Reply 7: In order to ensure sufficient residual esophageal length, we should not cut the length of the esophagus too long, should be within 4cm. If the tumor is located in the cardia, we should pay attention to where the upper limit of the tumor is located. Transabdominal esophagogastric junction adenocarcinoma resection should ensure that the upper boundary of the tumor invades the dentate line ≤ 2 cm. Of course, there are some difficulties in inserting a linear cutting stapler into the shortened esophageal stump, and we need further research to reduce this difficulty.

Reviewer B

The paper titled “Application of a linear cutter/stapler guiding device in overlap esophagojejunostomy after laparoscopic total gastrectomy: a preliminary study” is interesting. Application of the LCSGD in overlap EJS after laparoscopic total gastrectomy is safe and feasible, with satisfactory clinical effectiveness. However, there are several minor issues that if addressed would significantly improve the manuscript.

1) In the introduction of the manuscript, it is necessary to clearly indicate the knowledge gaps and limitations of prior study and the clinical significance of this study.

Changing in the text: We have modified our text as advised (see page 4, line-95 to 102).

2) The follow-up time of this study is too short, and it is recommended to extend the follow-up time and observe the long-term advantages of LCSGD.

Reply 2: We will follow up every six months to increase the follow-up time to observe the long-term advantages of LCSGD.

3) The number of patients in this study is relatively small and limited. It is recommended to increase the sample size and increase its application in some special populations, as the results may be more reliable.

Reply 3: At present, this study has just been put into use. In the future, it will increase the sample size, increase the use in different patient populations, and conduct bulk data research to further confirm the advantages of LCSGD, find deficiencies and make up for them.

Changing in the text: We have modified our text as advised (see page 11, line-310 to 313).

4) What is the biggest advantage of LCSGD? What is the biggest problem faced? How to overcome it? Suggest adding relevant content to the discussion.

Reply 4: The biggest advantage of LCSGD is that technique can shorten the time of digestive tract reconstruction, improve the reliability of esophagojejunostomy, reduce the formation of false passage, and improve the safety of surgery.

The biggest problem in this study is that the connection and removal of the linear cutting stapler and LCSGD need to be performed manually, which increases the operation time. We can study a complete linear cutting stapler containing LCSGD and put it into use. Changing in the text: We have modified our text as advised (see page 10, line-271 to 274).

5) The introduction part of this paper is not comprehensive enough, and the similar papers have not been cited, such as “Application value of continuous seromuscular layer sutures in the reinforcement of esophagojejunostomy in total gastrectomy for gastric cancer: a retrospective comparative cohort study, J Gastrointest Oncol, PMID: 36636057”. It is recommended to quote this article.

Changing in the text: We have modified our text as advised (see page 4, line-88).

6) What are the different effects of different treatment methods on the prognosis of laparoscopic total gastrectomy? It is recommended to add relevant content.

Changing in the text: We have modified our text as advised (see page 8, line-241 to 250).

Reviewer C

1) First, the authors should accurately and clearly indicate the clinical research design in the title, i.e., a case series of 10 patients undergone LCSGD-led overlapped EJS.

Changing in the text: We have modified our text as advised (see page 1 ,line 2 to 3).

2) Second, the abstract needs some revisions. The background did not indicate the knowledge gaps on the efficacy and outcomes of LCSGD-led overlapped EJS, the novelty of this study, and what the clinical significance of this study is. The methods need to describe the inclusion of the 10 subjects, their clinical characteristics, assessment of short-term efficacy and outcomes, follow up, and long-term outcomes. The results need to first report the baseline clinical characteristics of the 10 patients and follow up duration. The conclusion needs more detailed comments for the clinical implications of the findings.

Changing in the text: We have modified our text as advised (see page 1 to 2, line-31 to 61).

3) Third, in the introduction of the main text, the authors need to describe the rationale and mechanisms of LCSGD in detail to explain why it is helpful for overlap EJS. The authors need to clearly indicate the knowledge gaps on the outcomes of LCSGD-led overlapped EJS and the clinical significance of this study to support the

clinical needs for this study. Changing in the text: We have modified our text as advised (see page 4, line 95 to 102).

- 4) Fourth, in the methodology of the main text, please clearly describe the clinical research design of this study, assessment of baseline clinical factors, efficacy and safety outcomes and patient outcomes of the LCSGD-led overlapped EJS, and follow up procedures. Even the statistical analysis is descriptive only, the authors still need to have a separate part to describe the statistical software and main statistical methods.

Changing in the text: We have modified our text as advised (see page 5, line 135 to 155).