ANSWERING REVIEWERS

May 19, 2014

Dear Editor,

Please find enclosed the edited manuscript in Word format (file name: 10440-review.doc).

Title: Laparoscopic spleen-preserving distal pancreatectomy for pancreatic neoplasms: A retrospective study

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Name of Journal: *World Journal of Gastroenterology*

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The manuscript has been improved according to the suggestions of reviewers:

1 Format has been updated

2 Revision has been made according to the suggestions of the reviewers.
Comment from Reviewer 1
(1). Please describe briefly about the differences between laparosopic Kimura's method and Warshaw's method and their advantage.

Answer: Surgical techniques for LSPDP include conservation of the splenic artery and vein (Kimura's technique) and ligation of the splenic pedicle with preservation of the short gastric vessels (Warshaw's technique). Watshaw's technique has been shown to be associated with a shorter operation time, less blood loss, and a shorter hospitalization, and in general it is easier in practice. Actually, whether one approach is superior to another is still a matter of debate. Although the perioperative and functional results of spleen preserving distal pancreatectomy with splenic vessel resection seem acceptable in the short term, concern has been raised regarding potential long-term complications, including high incidence of left-sided portal hypertension and perigastric varices, with a theoretical risk of gastrointestinal bleeding.

(2). Format of the references have to accord to the journal request.

Answer: We have revised the format of the references according to the journal requirements.

(3). Polishing of English is needed.

Answer: We have had the paper polished in English by a native English speaking expert.

Comment from Reviewer 2

(1). As the authors state, the study is retrospective and is concerning a small population group. It is difficult to understand what does it mean "retrospective review of a prospectively maintained pancreatic surgery data base?" Could the authors better explain?

Answer: All data of our patients who underwent laparoscopic pancreatic surgery, including laparoscopic distal pancreatectomy, laparoscopic spleen-preserving distal pancreatectomy, laparoscopic central resection of pancreas and laparoscopic pancreatoduodenectomy, were documented in a data base of our hospital.

(2). In the Discussion it is cited a reported a high incidence of splenic vessels thrombosis after distal pancreatectomy with splenic vessels conservation. In spite of this the authors adfirm: "In our study, only part of the patients underwent the CT scan during the follow-up period to evaluate patency of the splenic vessel while the other patients only received B ultrasound examination because of economic reasons. Because of this, and partly due to the relatively short follow-up period, we did not see any patients with splenic vessel occlusion after preservation of the splenic vessels. We think that splenic vessels should be conserved as far as possible during spleen-preserving pancreatectomies" This last statement does not seem totally justified according to the previous considerations, The authors should better explain and justify the reasons for their preference.

Answer: As for the Warshaw's technique of LSPDP, concern has been raised regarding potential long-term complications, including high incidence of left-sided portal hypertension and perigastric varices during follow-up, with a theoretical risk of gastro-intestinal bleeding. In the Discussion, we cited the report by Yoon et al. who evaluated the short- and long-term patency of the splenic vessel in 22 patients after LSPDP with splenic vessel conservation. Vascular obliteration in the preserved artery and vein was found in 6 (27.3%) and 17 patients (77.3%), respectively, within a month of the surgery, and in 3 (13.6%) and 13 patients (59.1%) 6 months or more after the surgery. Nine of ten patients (90%) with complete splenic vein occlusion developed a collateral circulation during the late postoperative phase. The incidence of splenic vessel thrombosis after operation was observably high in this study, but we did not see any patient with splenic vessel occlusion after preservation of the splenic vessels in our study. The reasons for this may be that most of the patients only received B ultrasound examination because of economic reasons instead of CT scanning during the follow-up period. In addition, most of the patients underwent the operation in the recent two years, so the follow-up period was relatively short. Actually, in other studies, the incidences of splenic vessel thrombosis and perigastric varices were low and acceptable.

(3). Few points could be better discussed: pancreatic parenchima was sectioned by stapler or ultrasonic knife. What are the indications for both methods according to the authors esperience?

Answer: In most of the cases, pancreatic parenchima was sectioned by staple. But if it is difficult to reveal the splenic artery or vein when separating the upper and lower pancreatic border, we would use the ultrasonic knife to dissect the pancreatic parenchyma carefully to expose the vessels. In this study, two cases used the ultrasonic knife to dissect the pancreatic parenchyma.

⑷. Moreover, in presence of a thick pancreas, stapler closure may be difficult and not convincing. What are the alternatives proposed by the authors?
Answer: Staple closure may be difficult in presence of a thick pancreas. An appropriate ENDO-GIA is selected according to the size and thickness of the pancreas. Most of the cases, a 3.5 mm staple is used. For thickening pancreas and chronic pancreatitis, a 3.8 mm staple is selected.

⑸. In the "Introduction" in the 10th line from above "laparoscopic" should be written instead of "laparosopic"

Answer: The error has been corrected.

3 References and typesetting were corrected

Thank you again for publishing our manuscript in the *World Journal of Gastroenterology*.

Sincerely yours,

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