Point-by-point responses

Manuscript ID: **53588**

Invited Manuscript ID: **03475120**

Name of Journal: **World Journal of Gastrointestinal Surgery**

Manuscript Type: **Opinion Review**

Title: **Crucial anatomy and technical cues for laparoscopic transabdominal preperitoneal repair: Advanced manipulation for groin hernias in adults**

Corresponding author: **Tomohide Hori, PhD., MD., FACS.**, Editorial Board member of World Journal of Gastrointestinal Oncology (Number ID: 03475120)

Thank you for your valuable suggestions.

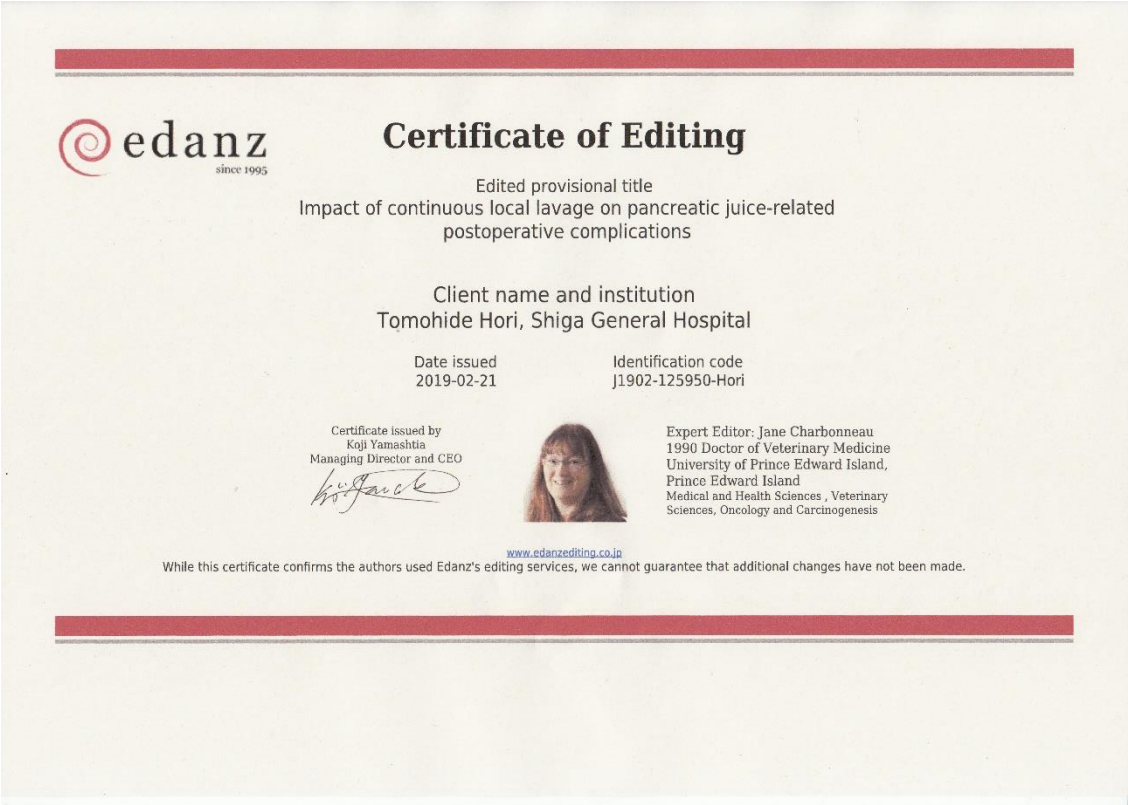
According to reviewers' comments, we revised our initial manuscript.

Please review our revised manuscript.

We prepared **Marked revised manuscript** and **Clear version**. In the marked version, additional mentions are in Red, and deleted sentences are shown in Red with strikethrough.

Also, this summary of responses (**Point-by-point responses**) was separately made.

English language: Manuscript (Main body, table and figures) has been already checked by English consultant (edanz editing, ordering ID: J1902-125950-Hori). I attached a Certificate for English language, with this letter.



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If you have any questions, please do not hesitate to contact me by e-mail.

Sincerely yours,

Tomohide Hori, PhD., MD., FACS.

Number ID: 03475120, Editorial Board member of World Journal of Gastrointestinal Oncology

To Reviewer number ID 02540153

Thank you for your valuable suggestion.

According to your suggestions, we revised our initial manuscript as described below.

‘Not only inguinal hernia repair, any surgery performed by the surgeon should have good anatomical knowledge and technical skills. Laparoscopic surgery and traditional open surgery have their own advantages and disadvantages, and TAPP and TEP have their own characteristics. TAPP has no higher requirements on anatomy than conventional open surgery, and the two have different surgical approaches and require different familiarity with anatomical sites. This article is rich and comprehensive, but not focused. After reading this article, I did not feel that those aspects can improve or change what practices.”

1. In the " COMPARISON OF TAPP AND TEP REPAIRS " paragraph, the following paragraph does not compare TAPP with TEP:“The laparoscopic approach offers the advantages of accurate diagnoses[2,33] , repair of bilateral and recurrent hernias[2] , less postoperative pain[2] , early recovery allowing work and activities[2] , TFR of the PPS[2] , ability to cover obturator hernias[59] , and avoidance of potential injury to the spermatic cord (SC)[2] . The disadvantages of the laparoscopic approach are the need for general anesthesia[2,36,37] , adhering to a learning curve[2] , higher cost[60] , unexpected complications related to abdominal organs[60,61] , adhesion to the mesh[2,61] , unexpected injuries to vessels[2] ,

prolonged operative time[60] , port-site hernia[2] , and as-yet-unknown long-term outcomes[62] . ”

Thank you for your valuable suggestion.

So sorry, our descriptions confused you.

TAPP repair is laparoscopic approach, though TEP repair is endoscopic approach.

At first, we clearly mentioned this point in the ‘Comparison of TAPP and TEP repairs’ section, as ‘TAPP and TEP repairs have advantages and disadvantages[2]. Briefly, TEP repair (*i.e.*, endoscopic approach) causes less pain, is associated with fewer intraperitoneal complications, and is technically less difficult[2]. TAPP repair (*i.e.*, laparoscopic approach) offers a better view of the anatomy and similar laparoscopic equipment across manufacturers, but it is more costly[2,58]. (page 9 line 15-19, in the Marked revised manuscript)’.

In the paragraph of ‘The laparoscopic approach (page 9 line 20-29, in the Marked revised manuscript)’, we described the advantage and disadvantages of TAPP (laparoscopic approach) in comparison with TEP (endoscopic approach).

According to your suggestion, we revised mentions from ‘laparoscopic approach’ to ‘TAPP’, in this paragraph. (Page 19 line 26-28, in the Marked revised manuscript).

“2. In the “POSTOPERATIVE COMPLICATIONS”: “Recurrence is a critical issue for general surgeons, and neuropathy may be intractable[82-84] . Postoperative complications include injury of the SC or the vas deferens (VD), which results in refractory pain with burning[85] ; testicular ischemia[86] or atrophy[87] ; bowel obstruction and/or necrosis due to mesh adhesion[61,88] ; vascular injury[89] ; visceral injury[61,88] ; wound infection[86] ; and/or hematoma[86] . Fatal outcomes

related to general anesthesia have been documented in rare cases[36,37]. ” Just listed a few complication names, no specific probability of occurrence. In fact, the incidence of complications after laparoscopic inguinal hernia repair and open hernia repair is not high, there are different complications after different surgical methods.’

Thank you for your valuable suggestion.

We agree your comments that the incidence of complications is not high, and each surgery may cause different complications.

According to your suggestion, we deleted this section in the revised manuscript (page 11 line 19-26, in the Marked revised manuscript).

To Reviewer number ID 01047350

Thank you for your valuable suggestions.

According to your suggestion, we revised our initial manuscript as described below.

‘This a very comprehensive and extensive review concerning the surgical anatomy of the inguinal area and the role of the anatomy in the various techniques that had been developed and applied in IH reconstruction. Title and references are adequate. The main text is well written and the figures very comprehensive with significant educational interest. The language is acceptable.’

‘I suggest to revise the abstract in order not to be so literature but more scientific

presenting the topic more precisely.'

Thank you for your valuable suggestion.

Some mentions seem to be not scientific.

According to your suggestion, at first, we deleted mentions in the revised manuscript (Page 3 line 3-9, in the Marked revised manuscript). Next, we added the mentions for scientific topic, as 'TAPP offers the advantages of accurate diagnoses, repair of bilateral and recurrent hernias, less postoperative pain, early recovery allowing work and activities, tension-free repair of the preperitoneal (posterior) space, ability to cover obturator hernias, and avoidance of potential injury to the spermatic cord. The disadvantages of TAPP are the need for general anesthesia, adhering to a learning curve, higher cost, unexpected complications related to abdominal organs, adhesion to the mesh, unexpected injuries to vessels, prolonged operative time, and as-yet-unknown long-term outcomes.' (Page 3 line 17-24, in the Marked revised manuscript).

To Reviewer number ID 03669557

Thank you for your valuable suggestions.

According to your suggestion, we revised our initial manuscript as described below.

'Good and detailed manuscript, however it is too long and tiring to read. Despite the excellent drafting, the manuscript should be streamlined, references and the use of acronyms should be reduced.'

Thank you for your valuable suggestion.

According to your suggestion, we deleted some paragraph, in the revised manuscript (page 11 line 19-26, in the Marked revised manuscript). Also, the number of references was reduced.

'Authors should rather insert their own experience. A scientific journal article should not look like a book chapter.'

Thank you for your valuable suggestion.

This article clearly focused on surgical techniques.

According to your suggestion, based on our experiences, we added mentions and made new figure (Added Fig. 13) of key point and pitfall during TAPP, in the revised manuscript, as 'The triangle of doom and triangle of pain configure a unique rhombus around the IEA. Laparoscopists should ensure an adequate laparoscopic view during the TAPP repair. Although downward view requires safe preservation of the VD and gonadal vessels and sure exposure of Cooper's ligament, downward view may easily mislead surgeons into unexpected injuries of topographic nerves and vessels (*e.g.*, GFN and femoral artery). Generally, a unique rhombus around the IEA seems to be a triangle on the upward view, and the ARM which is observed at the tangential wall is simultaneously observed at the ~~tangential wall~~ roof **(Figure ~~8~~ 13)**. In a word, intraperitoneal anatomy including the ARM should be simultaneously recognized by upward view, for adequate mesh placement during TAPP. Optimal change of laparoscopic view during TAPP is so important.' (Page 19 line 25-page 20 line 6, in the Marked revised manuscript).