Dear editors and reviewers

We thank you for your invaluable feedback and we hope that based on it, we made the adequate changes for the article to meet the publishing requirements. We answered to each checklist below (answers marked in italic)

Reviewer 1:

This is an interesting study describe an improvement of experience in surgical management of hydatid disease The study indicate that with advancement of skills in laparoscopic surgery even larger cysts of hydatid can be removed this was noted when comparison made to their previous treated patient using laparoscopic approach It is a retrospective study a limitation of such study Main advantage of laparoscopic approach was less wound infection and shorter hospital stay There are a few spelling mistakes and language can be improved

We thank you for the positive response and the feedback. We asked for help from your trusted sources to verify and adequately correct our manuscript to meet the standards!

Reviewer 2:

1 Title. Does the title reflect the main subject/hypothesis of the manuscript?

Reviewer: I think this title is gaudy and need to be clear. The subject of this study should be the comparison between laparoscopic treatment and open approach not the comparison with previous experience.

We removed the previous experience part, and we decided to stick with the original hypothesis, so that it will be clear. We kept the comparison with the previous experience in order to highlight the

improvements (or the faults) of the current laparoscopic experience. If required we can remove that as well.

2 Abstract. Does the abstract summarize and reflect the work described in the manuscript? Reviewer: Please check whether "10-year" is correct. Is it 12-year study? Besides, other parts also have this issue. Please check.

This is a 12 year study, the 10-year part I believe it was a typo, for which we apologize, we corrected that accordingly.

3 Key words. Do the key words reflect the focus of the manuscript? Reviewer: No. There is no key word. Need be added.

We initially added the keywords but for some reason, there are not present in the manuscript. The key words are as it follows liver hydatid disease, laparoscopic, cystobiliary fistula, follow-up

4 Background. Does the manuscript adequately describe the background, present status and significance of the study? Reviewer: It looks like the second paragraph is not finished. Please add.

We added it accordingly, one of the phrases was deleted, and the other was moved at the discussions section. We apologize for the inconvenience.

5 Methods. Does the manuscript describe methods (e.g., experiments, data analysis, surveys, and clinical trials, etc.) in adequate detail? Reviewer: There are more serious problems with this part.

1) Please check STROBE statement and add details as much as possible, such as selection criteria of patients included, blind information, the definition of remission, etc. For selection criteria, although research-ers said it should be maintained, they did not maintain selection cri-teria in this manuscript, which is a very important part in clinical tri-als. Results of clinical trials are usually not credible without selection criteria.

We added as many details regarding the strobe statement as well as we completed the checklist in an adequate manner (see number 13). We did have some selection criteria, however, compared with our previous article, that we wrote in 2013, we did not hold cyst size and cyst location as a selection criterion towards laparoscopic approach, because we wanted to highlight that experienced surgeons are able to perform surgeries even in a difficult setting (emphasis on experience).We corrected the methods sections accordingly, and we thank you for the suggestion.

2) Researchers indicated MRCP was used for some patients with serious symptoms. However, this step might cause selection bias. In another words, patients with relative minder symptoms might be more likely to underwent laparoscopic treatment, which might induce a relative better remission result in laparoscopic group. Please clarify this bias and add factors that affect the remission results, such as liver enzymes and hydatid elements, in Table 1.

Our database was retrospectively analyzed; therefore, we did not take this fully into consideration. However, as per your suggestion, we had a similar number of cases with preoperative hydatid elements in the CBD, as well as a relatively similar median liver enzyme levels. Therefore, there

were no significant preoperative differences between these parameters that can affect remission. We added that into the table as well as in the results sections, and we humbly thank you for the suggestion. We made sure to also add that preoperative MRCP might involve selective bias, which should be ascertained for future studies in this subject.

6 Results. Are the research objectives achieved by the experiments used in this study? What are the contributions that the study has made for research progress in this field? Reviewer: Yes, but still need to be modified.

1) In second sentence of part "Characteristics of the cysts and intraoper-ative parameters". One of "laparoscopic group" need to be deleted.

2) Please add the information of mortality in Table 2.

3) Please give a more detailed description about the finding of cut-off point. In ROC curve, please add P value and AUC. Besides, I think it is better to give the cut-off points of laparoscopic treatment and open approach, respectively.

1) We removed that.

2) We added the mortality in the second table accordingly, despite not encountering any fatalities during surgery or post-op and during the follow-up.

3) The main purpose of determining the cut-off value was to highlight the cyst size from which the risk of having cysto-biliary fistula is higher, disregarding the approach. We added a cut-off value for both treatments; however, the intention was to highlight the recommendation for MRCP based on the cyst dimension in order to assess the risk of cystobiliary fistula. In other words, our study suggests that MRCP should be routinely performed in cysts over 6.85 cm, as they pose a significantly higher risk of developing cystobiliary fistulas.

7 Discussion. Does the manuscript interpret the findings adequately and appropriately, highlighting the key points concisely, clearly and logically? Are the findings and their applicability/relevance to the literature stated in a clear and definite manner? Is the discussion accurate and does it discuss the paper's scientific significance and/or relevance to clinical practice sufficiently? Reviewer:

1) In paragraph 2, why is there no exclusion criteria?

The main reason was to highlight the fact that we did not exclude the cases approached laparoscopically in difficult segments. Due to improper wording this section was removed by accident. We added the exclusion criteria in this study, however we wanted to highlight the fact that cases were evaluated in their entirety, compared to our previous study which had more restrictive criteria.

2) In paragraph 3, researchers indicated mean difference gap of almost 6 years means the tendency that younger patients are more likely to choose laparoscopic treatment. Firstly, 39.87 and 44.36 are both around 40, which cannot reflect the difference of age. Secondly, the gap between 39.87 and 44.36 should be about 4.5.

Our aim was to find a possible explanation for the age difference. Despite statistically significant, indeed the mean age gap is relatively small (4.49). We corrected that accordingly, and left it as a possibility for interpretation. This can be considered a confounding variable.

3) Please add the limitation of this study.

We added them according to your suggestions and we thank you for that

8 Illustrations and tables. Are the figures, diagrams and tables sufficient, good quality and appropriately illustrative of the paper contents? Do figures require labeling with arrows, asterisks etc., better legends? Reviewer: All tables in manuscript are showed as pictures and not three-line format. Please check.

We redid the tables according to the three-line format, as well as adding a power-point with the tables for further editing/check-up. The tables as well as the figures will be accessible via a power-point presentation.

9 Biostatistics. Does the manuscript meet the requirements of biostatistics? Reviewer: Yes.

10 Units. Does the manuscript meet the requirements of use of SI units? Reviewer: Yes.

11 References. Does the manuscript cite appropriately the latest, important and authoritative references in the introduction and discussion sections? Does the author self-cite, omit, incorrectly cite and/or over-cite references? Reviewer: Yes. But format need to be checked. For example, in last sentence of first paragraph in part "Introduction".
We rechecked the format (see 4). One of the phrases was accidentally deleted. References were added appropriately

12 Quality of manuscript organization and presentation. Is the manuscript well, concisely and coherently organized and presented? Is the style, language and grammar accurate and appropriate? Reviewer: Please check STROBE statement.
We completed the STROBE statement accordingly and made the preparations in order to meet the requests.

13 Research methods and reporting. Authors should have prepared their manuscripts according to manuscript type and the appropriate categories, as follows: (1) CARE Checklist (2013) - Case report; (2) CONSORT 2010 Statement - Clinical Trials study, Prospective study, Randomized Controlled trial, Randomized Clinical trial; (3) PRISMA 2009 Checklist - Evidence-Based Medicine, Systematic review, Me-ta-Analysis; (4) STROBE Statement - Case Control study, Observational study, Ret-rospective Cohort study; and (5) The ARRIVE Guidelines - Basic study. Did the author prepare the manuscript according to the appropriate research methods and reporting? Reviewer: Researchers uploaded a signature of STROBE statement without a full list of STROBE statement. Please add.
We uploaded it alongside the revised manuscript.

14 Ethics statements. For all manuscripts involving human studies and/or animal experiments, author(s) must submit the related formal ethics documents that were reviewed and approved by their local ethical review committee. Did the manuscript meet the requirements of ethics? Reviewer: Yes.

Greetings. Based on the suggestion received from the e-mail, we added our point-to-point response for our reviewer. We would like to thank you for taking your time into receiving and helping us process this article. Below is our point-by-point response. Thank you for your time.

Revision reviewer

Specific comments to authors

Thanks for researchers' correction. This manuscript has improved a lot, but still need minor revision. 5 Methods. Does the manuscript describe methods (e.g., experiments, data analysis, sur-veys, and clinical trials, etc.) in adequate detail?

Response: *We have addressed that in our previous review, this may have been a copy-paste. The manuscript describes all of the methods, as well as the data analysis. This is reflected in the STROBE criteria which we already attached. If required, we can re-post them again.*

Reviewer: There are more serious problems with this part.

1) Please check STROBE statement and add details as much as possible, such as selection criteria of patients included, blind information, the definition of remission, etc. For se-lection criteria, although research-ers said it should be maintained, they did not maintain selection cri-teria in this manuscript, which is a very important part in clinical tri-als. Results of clinical trials are usually not credible without selection criteria.
Researchers: We added as many details regarding the strobe statement as well as we completed the checklist in an adequate manner (see number 13). We did have some selection criteria, however, compared with our previous article, that we wrote in 2013, we did not hold cyst size and cyst location as a selection criterion towards laparoscopic approach, because we wanted to highlight that experienced surgeons are able to

perform surgeries even in a difficult setting (emphasis on experience). We corrected the methods sections accordingly, and we thank you for the suggestion.

Re-reviewer: The objective of this study is to compare the patients' outcomes of laparoscopic treatment and the open approach. Hence, included patients of two types of operations need to be comparable. Of course, experienced surgeons can get severe patients to include, which makes included patients are more comprehensive? If so, it is also needed to be comparable between two groups of patients. I am not clear why researchers emphasize the experience of surgeons. If the basis of included patients cannot be controlled, I think researchers need to address this issue in Discussion section.

Response: We've readdressed this by highlighting the exact inclusion and exclusion criteria as well as pointing out this in the discussion section, as per your suggestion. Although the basis of the included patients was controlled, we somehow wanted to highlight the fact that experience of the surgeon may be a criterion which is too subjective to input. All cases respected the inclusion/exclusion criteria flowchart, with both groups benefitting from the same rigorous case-selection methods, for the groups to be comparable. We've also added this in the discussions section, and we thank you again for the feedback.

2) Researchers indicated MRCP was used for some patients with serious symptoms. However, this step might cause selection bias. In another words, patients with relative minder symptoms might be more likely to underwent laparoscopic treatment, which might induce a relative better remission result in laparoscopic group. Please clarify this bias and add factors that affect the remission results, such as liver enzymes and hydatid elements, in Table 1. Researchers: Our database was retrospectively analyzed; therefore, we did not take this fully into consideration. However, as per your suggestion, we had a similar number of cases with preoperative hydatid elements in the CBD, as well as a relatively similar median liver enzyme levels. Therefore, there were no significant preoperative differences between these parameters that can affect

remission. We added that into the table as well as in the results sections, and we humbly thank you for the suggestion. We made sure to also add that preoperative MRCP might involve selective bias, which should be ascertained for future studies in this subject. **Re-reviewer: Thank you for your correction. Please add unit of value. And please add "We made sure to also add that preoperative MRCP might involve selective bias, which should be ascertained for future studies in this subject." in Limitation part.**

Response: We added the units of value as well as the phrase into the Discussions section, common with the previous point, to highlight the risk of bias. Thank you for the tips.

6 Results. Are the research objectives achieved by the experiments used in this study? What are the contributions that the study has made for research progress in this field? Reviewer: Yes, but still need to be modified. 2) Please add the information of mortality in Table 2. 3) Please give a more detailed description about the finding of cut-off point. In ROC curve, please add P value and AUC. Besides, I think it is better to give the cut-off points of lapa-roscopic treatment and open approach, respectively. Researchers: 2) We added the mortality in the second table accordingly, despite not encountering any fatali-ties during surgery or post-op and during the follow-up. 3) The main purpose of determining the cut-off value was to highlight the cyst size from which the risk of having cysto-biliary fistula is higher, disregarding the approach. We added a cut-off value for both treatments; however, the intention was to highlight the recommendation for MRCP based on the cyst dimension in order to assess the risk of cystobiliary fistula. In other words, our study suggests that MRCP should be routinely performed in cysts over 6.85 cm, as they pose a significantly higher risk of developing cystobiliary fistulas. **Re-reviewer: 2) Thank you for your correction. I think it is more suitable to add the information of mortality in Table 5. 3) Please add the information of cysto-biliary fistula in Table 4. From ROC, we can see the cut-off point of open surgery is higher than laparoscopic surgery, which indicates the risk of cysto-biliary fistula in open**

surgery might be lower than that of laparoscopic surgery. It would better to compare them in Table 4.

Response: We've added the information regarding cystobiliary fistula as well as a comparison for the cut-off values in table 4, according to your suggestion. We moved the mortality in table 5 as well. Thank you for the suggestion!

We would like to thank both the editors and our reviewer for the collaboration into making our article better.