

Dear editors,

I have revised my manuscript according to your comments and suggestions. Meanwhile, I would like to answer your questions as follows.

1、 This is a retrospective comparative study regarding 3D laparoscopic-assisted versus open gastrectomy for carcinoma in the remnant stomach. The study design is relevant and the case number is relatively large for this rare disease. **However, most of published studies compared 3D with 2D laparoscopic surgeries. Please specify why the authors compared 3D laparoscopic surgery with open surgery?** It is difficult to identify the differences between the two groups coming from 3D or laparoscopy effect.

Traditional laparoscopy provides a 2-dimensional field of vision, lacks spatial and hierarchical perception, and has a long learning curve for the surgeon. 3D laparoscopy makes up for the shortcomings of traditional laparoscopy by providing a three-dimensional and hierarchical sense that allows surgeons to obtain a field of vision similar to open surgery. In other side, compared with open surgery, 3D laparoscopic surgery has a magnified view of local surgical field and gains a better and clearer anatomical structure, thus making it easier and more precise to perform the delicate procedures such as dissection, separate tissues, stop blood and ligate vessels, especially in complicated surgery.

Our hospital began to introduce 3D laparoscopic equipment in 2015, which is widely used in gastrointestinal surgery. In traditional opinion, most scholars believed that the history of upper abdominal surgery was relatively contraindicated for laparoscopic surgery, and most patients with remnant gastric cancer were treated with open surgery. With the rapid development of 3D laparoscopic equipment, 3D laparoscopic assisted gastrectomy shows huge advantages such as clear anatomical level, less bleeding, small incision, more minimally invasive, more flexible in narrow space, postoperative recovery quickly. 3D laparoscopic technology is a big step forward for "minimally invasive surgery" and "precision surgery".

**2、 As the case number is too small to reach statistical differences in the proximal gastrectomy subgroup, I suggest removing these patients from the present study.**

In the current clinical practice, as the increasing number of patients with early gastric cancer undergoing proximal gastrectomy, the number of remnant gastric cancer after proximal gastrectomy will increase. However, due to the small number of patients enrolled in the proximal gastrectomy subgroup, the difference between OGC and 3DLGC in this subgroup may not be effectively explained. In our study, the basic information of patients with remnant gastric cancer who had previously undergone proximal gastrectomy didn't reach statistical difference between the OGC and the 3DLGC group. Therefore, we cancel stratified analysis, but keep these patients in the overall study population. In the future, we expect to expand the number of cases in the proximal gastrectomy subgroup for further study.

**3、 The "Introduction" and "Discussion" sections are wordy. Please focus on the key background & study findings and give relevant discussions.**

The "Introduction" and "Discussion" sections have been revised.

**4、 What was the proportion of patients involved in enhanced recovery after surgery (ERAS) protocol in OGC group compared with that in 3DLGC group? Were they similar? The ERAS protocol definitely had an impact on patient recovery.**

ERAS is a series of effective and optimal treatment measures confirmed by evidence-based medicine in the perioperative period to reduce patient stress and promote early recovery. It runs through all aspects of the perioperative period. The core measures of ERAS protocol include preoperative education and evaluation, avoidance of mechanical bowel preparation, prevention of thrombosis and infection, perioperative anesthesia management, prevention of intraoperative hypothermia, minimally invasive surgery, early removal of gastric tube, early ambulation and early postoperative oral intake, etc. The purpose of ERAS is to promote the patient recovered quickly, so ERAS is not a fixed protocol. Take considerations of the

difficulty in accomplishing necessary compliance to all protocol items, we hold the opinion that the patient got into the management of ERAS as long as adopting some of the ERAS protocols. Development of individualized ERAS programs has also been put on the agenda by various medical centers.

All patients with CRS enrolled in this study underwent preoperative education and evaluation, intraoperative stretch socks for thrombosis prevention, intraoperative warmth, postoperative multi-mode analgesia, encouragement of early ambulation, and postoperative enteral and parenteral nutrition support, which were in line with ERAS protocols. But we think minimally invasive surgery was the cornerstone of ERAS.

**The rest of problems mentioned in comments have been revised in the manuscript. And decomposable figures and three-line tables have been submitted.**