Dear BPG Editorial Office editors and reviewers,

We sincerely thank the editor and all reviewers for their valuable feedback that we have used to improve the quality of our manuscript. The reviewer comments are laid out below in italicized font and specific concerns have been numbered. Our response is given in normal font and and the changes/additions to the manuscript are attached below with "Corresponding modifications".

For reviewer #1

Comment 1 *"In the US, this disease ranks 10th and 9th among males and females, respectively", is unclear statement. "The morbidity rate of this disease" is correct.*

Response: We appreciate and accept your suggestion. The incidence rate of pancreatic cancer of different genders has been shown in the revised manuscript.

Corresponding modifications: In the US, the PC incidence rate ranked 10th among males and 8th among females in 2022[1]

Comment 2 *This disease is currently classified into four types for clinical management: resectable pancreatic cancer (RPC), borderline resectable pancreatic cancer (BRPC), locally advanced pancreatic cancer (LAPC), and unresectable pancreatic cancer (URPC). This statement is not correct. LAPC means locally advanced unresectable cancer. Unresectable pancreatic cancer (UR) is divided into locally advanced unresectable cancer (UR-LA) and metastatic cancer (UR-M). Please read the reference No. 15: In Table 1 of this paper, the criteria of respectability of Alliance, PJS and NCCN are shown with regard to R, BR (BR-PV, BR-A), UR (UR-LA, UR-M).*

Response: We appreciate and accept your suggestion. The criteria of respectability of pancreatic cancer has been rewritten according to reference NO.15 in the revised manuscript.

Corresponding modifications: This disease is currently classified into four types for clinical management: resectable pancreatic cancer (RPC), borderline resectable pancreatic cancer (BRPC), and unresectable pancreatic cancer, including locally advanced pancreatic cancer (LAPC) and metastatic pancreatic cancer. BRPC is further divided

into pancreatic cancer with arterial invasion (BR-A) and pancreatic cancer with superior mesenteric vein/portal vein invasion only (BR-PV)[15].

Comment 3 *"At a median follow-up of 59 months, the neoadjuvant chemoradiotherapy group had an OS of 15.7 months, while the upfront surgery group had an OS of 14.3 months (HR, 0.73; 95% CI, 0.56–0.96; P = .025)." Is not correctly mentioned. In this sentence, OS means medial survival time (MST). This should be clearly mentioned.*

Response: We appreciate and accept your suggestion. In this part, the "OS" in this section has been changed to "MST" in the revised manuscript.

Corresponding modifications: At a median follow-up of 59 mo, the neoadjuvant chemoradiotherapy group had a median survival time (MST) of 15.7 mo, while the upfront surgery group had a MST of 14.3 mo (HR, 0.73; 95%CI, 0.56-0.96; P = .025).

Comment 4 *The term, "total neoadjuvant therapy (TNT)", should be clearly defined. In the title of paragraph, you use the term, total neoadjuvnat chemotherpay. However, the reference No 49 defines the TNT as systemic chemotherapy followed by chemoradiation (CRT). Additionally, the reference No 50 stated that TNT which included a minimum of 4months of chemotherapy followed by 1 month of CRT prior to surgery. The author should clearly define the term of TNT.*

Response: We appreciate and accept your suggestion. In the title of paragraph, We have rewritten "Total neoadjuvnat chemotherpay" to "Total neoadjuvnat thermopay". The definition of TNT has been supplemented in the revised manuscript and corresponding references have been added.

Corresponding modifications: TNT was designed to provide postoperative adjuvant therapy in a preoperative setting and includes concurrent chemoradiotherapy delivered before or after systemic

chemotherapy[159].

Comment 5 *"The standard lymph node dissection ranges are 5, 6, 8a, 12b1, 12b2, 12c, 13a, 13b, 14a, 14b, 17a, and 17b" is not correct. This is used for pancreatoduodenectomy (that is, pancreatic head cancer). While for cancer of the body and tail is removal of stations 10, 11, and 18 is standard.*

Response: We appreciate and accept your suggestion. The standard lymph node dissection ranges for cancers of pancreatic body and tail have been added in the revised manuscript.

Corresponding modifications: For cancers of the pancreatic body and tail, dissection of stations 10, 11, and 18 is standard and dissection of station 9 is only recommended for patients with cancer of the pancreatic body[120].

For reviewer #2

Comment 1 *However I found some acronyms that were not explained in the text or described below. For example, at page 19 when dealing with lymphadenectomy you wrote EPD and SPD without explanation. Moreover, CAR was explained in the paragraph next to the sentence in where you wrote it.*

Response: We appreciate and accept your suggestion. The abbreviations "EPD" and "SPD" have been explained in the revised manuscript.

Corresponding modifications: A series of meta-analyses showed no significant increase in the median survival time and 1-, 3-, and 5-year survival rates of patients receiving extended lymphadenectomy in pancreaticoduodenectomy (EPD) versus standard lymphadenectomy in pancreaticoduodenectomy (SPD) and an increased risk of complications[118, 119].

Reference

1 **Siegel RL**, Miller KD, Fuchs HE, Jemal A. Cancer statistics, 2022. *CA Cancer J Clin* 2022; **72**: 7-33 [PMID: 35020204 DOI: 10.3322/caac.21708]

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119 **Dasari BV**, Pasquali S, Vohra RS, Smith AM, Taylor MA, Sutcliffe RP, Muiesan P, Roberts KJ, Isaac J, Mirza DF. Extended Versus Standard Lymphadenectomy for Pancreatic Head Cancer: Meta-Analysis of Randomized Controlled Trials. *J Gastrointest Surg*

2015; **19**: 1725-1732 [PMID: 26055135 DOI: 10.1007/s11605-015-2859-3]

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