ANSWERING REVIEWERS

Dear Editor,
We would like to thank all the reviewers for their very helpful and detailed comments. In the following section these comments are answered individually and the appropriate changes are made in the text and highlighted.

Reviewer 00503228

1. Methods: Surgical Technique: Were all of your LLDNs purely laparoscopic or the hand-assisted technique was also used in some of them? If yes, what were the differences?
We would like to thank the reviewer for the question. The LLDNs were all done with the hand-assisted technique for reasons of safety. This is highlighted in the text in the "Methods" section and the procedure is described in detail.

2. Results: Early (acute) and late complications are needed to be given.
We would like to thank the reviewers for their comment. In the results section it was reported that all of the complications were in the immediate postoperative period, with the exception of two cases of ileus in the open LDN group which occurred after the six month period. The added sentences are highlighted.

3. Results: "...presence of cysts, size, presence of stones and a tortuous ureter..." Please compare them between the two groups.
We would like to thank the reviewer for the point and we have added the following sentences in the text: "Specifically, in the LLDN out of the 19 right nephrectomies, the right kidney was chosen in 15 donors because of a single artery, in 2 patients because of the presence of numerous cysts mainly on the right side and 1 patient because of a significant size difference with the left kidney being much larger than the right and in 1 patient because of the presence of stones in the right kidney that were removed ex vivo. In the case of the open LDN, there were 55 right kidneys used. Out of these, in 43 patients the right kidney was chosen because of a single artery, in six patients because of size differences between the two kidneys, in 4 patients because of the presence of cysts on the right kidney and in two patients because of a tortuous ureter. The small sample size did not allow for statistical differences between the two groups".

4. Results: "This serves to show the importance of the learning curve, as the continued experience with the laparoscopic procedure led to increased intraoperative efficiency, resulting in decreased surgical time." Remove from the results section and relocate it in the discussion section.
We would like to thank the reviewer about the comment. The sentence is removed from the "Results" section and there is a highlighted sentence in the discussion section.

5. "Another example of this is the number of conversions, which were a total of 18/279 (6.45%)." You may summarize the data in a table.
We would like to thank the reviewer for the comment. The sentence was summarized in a new Table, Table 4.

6. "Reasons for conversion inlcuded anatomy (5 patients), bleeding (8 patients), and adhesions (5 patients)." You should give description of each of the five; including If any of the donors

needed a reoperation after the nephrectomy; due to post-op complications? Any readmittion? Any DVT, INFECTION, EARLY GRAFT LOSS …?
We would like to thank the reviewer for the comment. A sentence was added to the text regarding the fact that there were no reoperations or readmissions in these donors.

7. "both the preoperative creatinine values (LLDN=0.96 ± 0.4 mg/dL versus OLDN=0.88 ± 0.4 mg/dL) and the postoperative ones at 1 month (LLDN=1.43 ± 0.9 mg/dL versus OLDN=1.39± 0.8 mg/dL) were similar between the two groups (Table 1)" The first "preoperative creat" is far less than the postop creat. It is a disaster! Unless the postop creats are the recipients' creat! If it is true, you should say it: whose creat you mean, either in giving the preop, and the postop values.
We would like to thank the reviewer for the comment. We would respectfully disagree with the statement that "it is a disaster" as an increase in the donor postoperative creatinine is not uncommon. Additionally, these numbers are not terribly different between the open and laparoscopic and we would also like to point out that they are in the early postoperative period (1 month) with potential for improvement.

8. "The one area where there was a statistically significant difference between the two groups was the length of stay " Please give values to the time "days, weeks, …) and also give p value for it.
We would like to thank the reviewer for the comment. The values to the time and the p value are provided in Figure 4 (referring to "days" on the y axis).

9. "something which is not unexpected considering the larger incision " In the result section, in several occasions you discuss the issue; in the Results section you may only give the pure facts and analyses, and leave the discusses to the discussion section.
We would like to thank the reviewer for the comment. We have accordingly removed the sentence from the results and added it in the discussion section.

10. DISCUSSION: DISCUSS LIMITATIONS: 1. Your report is not randomized. It is a major limitation mudding all your findings. In fact, with this limitation, you might better to give just your series without much insists on comparing outcomes.
We would like to thank the reviewer for his observation. Accordingly, it was added in the discussion as part of the limitations that this is a retrospective study.

11. The discussion is not started properly; the first two quotations should be presented in the methods section.
We would like to thank the reviewer for the comment. The reason for the first two quotations is to review the nature of the study and the results for the reader. Obviously, if the reviewer feels strongly about this, we could remove them altogether.

12. Figure 3 is vague (at least to me).
We would like to thank the reviewer for his point. Figure 3 in the original version is now Figure 1 in the revised version. It shows the decrease of operating time for laparoscopic LDN over the years. However, as the reviewer points out, to make it clear we have added the legend "Operating time (minutes)" for the y axis.

13. Figure 5: The figure shows some worse conditions for the LLDN vs. OLDN. In calculating the mean+/-SD have you included those who represented delayed graft function? Moreover, the number of patients in the OLDN seems to be less than what you proclaim.
We would like to thank the reviewer for the comments. Figure 5 in the original version is now Figure 3 in the revised version. There is no difference in the analysis between the open vs. the laparoscopic. The ones representing delayed graft function have been included. The number of patients in the OLDN are a total of 211 pts (156 pts L nephrectomy and 55 pts R nephrectomy).

14. Figure 6: Figure 6 is not necessary; better to get removed.
We would like to thank the reviewer for the comment. Figure 6 in the original version is now Figure 4 in the revised one. We are hoping to show with that figure the difference in length of stay between the open and laparoscopic procedures, including the statistical analysis. We chose the figure as we feel that it will be easier for the reader to visualize these data, rather than raw descriptive text.

15. Table 1: last row "major complications" it needs elucidation.
We would like to thank the reviewer for the comment. Table 1 in the original is currently Table 2 in the revised version. We have detailed that in the text with the types of complications mentioned.

16. Table 1: a column of P value needed.
This refers to the current Table 2 (after the tables and figures were changed according to other reviewer comments) and no P value was marked as the differences between the two groups do not reach statistical significance and as such we have followed the instructions of BPG that "non-significant values, i.e. $P > 0.05$ do not need to be indicated". Essentially the table shows that there is no statistically significant difference in the categories mentioned between the open and the laparoscopic group.

17. Table 1: These data are needed to be added: Age; gender; BMI; relation to the patient (related vs. unrelated); HLA-(and/or other) matching; warm ischemia time, vessel length (artery, vein), analgesic requirement, pain intensity (if evaluated), major complications (bleeding, infections, , bowel obstructions, perforations ureteral stricture, thrombosis, early graft loss, …)
We appreciate the reviewer's point. Table 1 in the original is currently Table 2 in the revised version. This data has not been collected for this paper, but will be collected for a subsequent one.

Reviewer 00502999
1. This paper is about nephrectomies in living donors in Kidney transplantation comparing Laparsocopic vs traditional approach. It is retrospective, and this issue must be more highlighted, as the period included in the study is from 1998 to 2009,and many technical and technologic changes have gone by. It is mentioned by the authors, but could be better addressed.
We would like to thank the reviewer for his accurate statement. Accordingly, we are mentioning this specifically as part of the limitations at the end of the discussion.

2. Page 3, Conclusions: THE WAY OF THE FUTURE. please, delete this phrase. It does not belong to scientific languague.
We would like to thank the reviewer for this point. We have accordingly changed the wording to say "the preferred method".

3. The authors employ "you"as the subject of sentences in many parts of the paper. This colloquial way of writing is unacceptable.
We would like to thank the author for the comment. Wherever applicable this has been corrected.

4. One interesting point to discuss, considering the fact that the learning curve is part of the laparoscopic disadvantages in the first surgeries performed by a single surgeon, is: What if laparoscopic nephrectomies were included in General Surgery Training programs?. Are the same techniques and cares performed in nephrectomies in disposable kidneys (say, due to cancer) vs in living donors?.It appears not to be so. Please include these aspects in the discussion.
We would like to thank the reviewer for this comment. The following paragraph was added in the discussion: "Another point having to do with the learning curve is the transfer of surgical knowledge and training. Specifically, in order to train the next generation of surgeons performing laparoscopic living donor nephrectomies, the attending performing the surgeon needs to train the fellow, and potentially the general surgical resident. However, given the fact that there is no room for errors in the case of living donation, the best way to start is in the case of laparoscopic nephrectomies performed for other etiologies, such as malignancy or infection. This way the trainee can "graduate" to the more complex procedure".

5. Introduction. Please employ paragraphs!!!.
We would like to thank the reviewer for the comment. Paragraphs were employed.

6. By the end of page 6, authors state the living donor is the most important patient in the hospital...This is unacceptable. All patients are equally important to physicians. Please delete this unfortunate sentence.
We would like to thank the reviewer for the comment. The point is that the living donor is a very special case of a patient who undergoes a major surgical procedure without any biological or physical benefit for his or her health. That is a rare situation in medicine and surgery. Even so, the sentence was changed to reflect the reviewer's comment.

7. Page 8, Surgical technique. NSAIDS (ketorolac) are discouraged to be employed in donors. If authors employ them in postsurgical nephrectomies, must defend their pain protocol with their experience and results. Again, paragraphs are scant all over the manuscript.
We would like to thank the reviewer for the comments. Regarding the use of Ketorolac, the sentence was added that it was only used with limited dosing and only for one day. We have not had any issues, as all the patients receive gastric ulcer prophylaxis as well. Additionally, paragraphs were created.

8. Discussion: Line 2, page 10: Revelas? reveals. The grammar of pages 10 and 11 is disorganized and not well-structured. Please redo. In my opinion, the first to lines of page 11 are unfortunate. Page 11, line 11: What is the meaning of the word INSEPCT?. Again, in line 8 they use the colloquial "you can". Have the authors ever found this way of writing in a serious paper? First lines of last paragraph of page 11 are confusing. Page 12: Please delete "These elements of.....donor".
We would like to thank the reviewer for the comments. Changes were made accordingly and highlighted in the text.

9. Address the limitations of the study, in which the period observed (more than a decade) and the fact of being retrospective must be underscored.
We would like to thank the reviewer for this important point. Indeed in the last paragraph the limitations of the study (time period, retrospective nature and single center) are mentioned specifically.

10. Too many figures. Please reduce the number to 3. Figures 1 and 2 are not Figures the way the appear in the file.They look as Tables.
We would like to thank the reviewer for the comment. Figures 1 and 2 were changed to Tables 1 and 2.

Reviewer 00503339
Message clear and truly worthy of wide dissemination. One point that might have been made is whether contemporary skills in decision making during laparascopic donor nephrectomy are uniformly present in surgeons and urologists who will collect donor kidneys or prepratory training is needed to allow broad acceptance of the technique as the new "standard" for collecting live donor kidneys. A plasure to read!
We would like to thank the reviewer for these comments. A sentence was added in the discussion regarding the excellent point that the reviewer is making having to do with the skills required.