

Reviewer comment 1:

*Issues raised:*

*1.How many SPKT were performed in the authors' center during the study period? How many were excluded from the study and for what reasons?*

*2.This is a retrospective study. The authors should specify if there are elements that could have influenced the decision to perform NSL or SL. This is important to exclude any possible selection bias.*

*3.In the Methods, the authors say that the surgical team who performed NSL had a higher experience in SPKT than that who performed SL. Can the authors comment on this?*

*4.The authors should specify if duodenal decontamination was performed routinely during pancreas procurement.*

*5.The authors should specify pancreas procurement if the 2 groups received the same anticoagulation prophylaxis.*

Reply

Thank you very much for your comment!

1. From January 2016 to December 2019, 138 SKPT were performed in our center, and 134 patients were included in this study. two patients with graft pancreatectomy due to thrombosis within the first postoperative week were excluded from the study; and one patient was excluded from the study because the patient was diagnosed a ascending colonic diverticulum by colonoscope before transplantation and experienced hemorrhage of diverticulum after SPKT; and one patient was excluded from the study due to history of duodenal ulcer bleeding. We clarified this issue in study subjects of the manuscript revision.

2. From the first outpatient visit, during the period of preoperative evaluation, operation, and follow-up after SPKT, a patient will be under constant supervision by the same doctor team in our center. In order to decrease EA bleeding rate in SPKT, the doctors in SL group

proposed the conception of suture ligation for submucosal hemostasis during hand-sewn side-to-side duodeno-ileostomy and applicated this technique from January 2016. In this study, if a patient was supervised by the doctor who is the corresponding author of this paper, then the patient was allocated into SL group. If a patient was not supervised by the doctor who is the corresponding author of this paper, then the patient was allocated into NSL group. The cases before January 2016 in our center were excluded from this study. There were no other criteria for grouping. We clarified this issue in surgical techniques of the manuscript revision.

3. Enteric anastomoses in the SL group were performed by a relative younger surgical team, which had a lesser experience in SPKT. In order to decrease EA bleeding rate in SPKT, the doctors in SL group proposed the conception of suture ligation for submucosal hemostasis during hand-sewn side-to-side duodeno-ileostomy and applicated this technique from then on. The surgical team in the NSL group possessed much more surgical experience, and should achieve lower GI bleeding rate than the relative younger surgical team in SL group, but the boot is on the other leg. So we think that the plication technique affected the EA bleeding rate more than surgical experience in this study, leading to decreasing the EA bleeding rate in SL group.

We clarified this issue in surgical techniques and discussion of the manuscript revision.

4. In our center, for the duodenal decontamination, lavage technique via the nasogastric tube was performed routinely with normal saline ( 500 ml), and then metronidazole solution ( 200 ml) was instilled during pancreas procurement. We clarified this issue in surgical techniques of the manuscript revision.

5. The two groups received the same anticoagulation prophylaxis. We clarified this issue in prophylactic anticoagulation therapy of the manuscript revision.