Response Letter

Dear Editor,

Thank you very much for sending us the valuable comments of the two kind Reviewers on our manuscript entitled "**Comparison of SIL-TAPP and CL-TAPP repair in the treatment of adult female patients with inguinal hernia: A single-centre retrospective study**" **(Manuscript Number: 87479)**, which is very helpful to improve the quality of our paper. We have carefully considered the comments and tried our best to revise the manuscript accordingly. In addition, the manuscript has been rewritten by professional language editors and native English-speaking medical experts to improve its readability and quality. All revised contents have been highlighted in yellow color in the revised manuscript. Furthermore, point-by-point responses to the two kind Reviewers are listed below this letter.

Thank you for allowing us to resubmit a revised copy of the manuscript. We hope that the revisions in the manuscript and our accompanying responses will be sufficient to make our manuscript suitable for publication in ***World Journal of Gastrointestinal Surgery***.

Best regards.

Yours sincerely,

Peng Wang

E-mail: dankongwang@ntu.edu.cn

Response to Reviewer #1

1. *The study does not mention whether the two different procedures were done by the same surgeon. There will be bias if this was performed by different surgeons.*

Reply: Thank you very much for your reminder. We are really sorry for our carelessness. In fact, all of the SIL-TAPP and CL-TAPP repair surgeries included in this study were performed by the same surgeon, so there was no selection bias. In line with your comment, we have added a description of the operators of the SIL-TAPP and CL-TAPP procedures in the **Research design and patients** section as follows: "All procedures included in this study were performed by the same surgeon."

2. *Also, the authors have to clarify whether the injury to the inferior epigastric artery occured during port insertion or during the flap elevation.*

Reply: Thank you very much for your careful reading and valuable comments. As stated in our article, four cases of the inferior epigastric vessel injuries occurred in the

CL-TAPP patient cohort, all of which occurred at the time of trocar placement on both sides, one on the left and three on the right. We strongly agree with your comments, and therefore we have added a description of the course of the inferior epigastric vessel injuries in the **RESULTS** section as follows:

"All four cases of injury to the inferior epigastric vessel occurred at the time of trocar placement on both sides, one on the left and three on the right."

3. The total size of the umbilical port in SILS-TAPP is also not mentioned.

Reply: Thank you very much for your reminder. In the SIL-TAPP repair procedure, we generally make a longitudinal incision of approximately 2 cm in the umbilicus and place one 10 mm trocar and two 5 mm trocars. We strongly agree with your suggestion, and therefore we have added a description of the size of the umbilical incision in the **Surgical techniques** section as follows:

"In SIL-TAPP repair, we generally made a longitudinal incision of approximately 2 cm in the umbilicus and placed one 10 mm trocar and two 5 mm trocars."

4. The port closure techniques are not mentioned in the methodology.

Reply: Thank you very much for your great point. The closure of the median longitudinal incision in the umbilicus has been described in great detail in our previous study (Single-incision laparoscopic transabdominal preperitoneal

hernioplasty: 1,054 procedures and experience. Hernia. 2023, 27(5): 1187-94). For the midline longitudinal incision of the umbilicus, the suture was usually divided into two layers. First, the umbilical fascia layer was sutured continuously with 1-0 v-lock sutures, and then the midpoint of the standing flap at the umbilical ring was sutured with an absorbable protein line. Both ends were sutured intradermally, and the rest were sutured intermittently. After blood was cleaned with gauze, the standing flap was pushed back to the umbilical fossa to achieve a perfect repair. Based on your comments, we have added a description of the median longitudinal incision suture in the umbilicus in the **Surgical techniques** section as follows:

"For the midline longitudinal incision of the umbilicus, the suture was usually divided into two layers. First, the umbilical fascia layer was sutured continuously with 1-0 v-lock sutures, and then the midpoint of the standing flap at the umbilical ring was sutured with an absorbable protein line. Both ends were sutured intradermally, and the rest were sutured intermittently. After blood was cleaned with gauze, the standing flap was pushed back to the umbilical fossa to achieve a perfect repair."

Response to Reviewer #2

General comments: Dear author, great work to study an area of interest, whoever you need to clarify some points:

Reply: Thank you for your careful reading and detailed comments. These suggestions fully demonstrate your unique academic insights and profound academic attainments, which have brought great enlightenment and help to our scientific thinking. We have revised the manuscript according to your requirements and hope that it will meet your needs. Here are my point-by-point answers to your questions:

1. *At Abstract section of your study, your conclusion is short and deficit.*

Reply: Thank you very much for your constructive suggestion. We were previously unable to adequately express our conclusions due to the journal's limitations on the length of the **Abstract**. Based on your suggestion, we have revised the **Abstract** and described the **Conclusion** section of the **Abstract** in more detail as follows:

"SIL-TAPP repair did not increase the incidence of intraoperative and postoperative complications in female inguinal hernia patients. Moreover, female inguinal hernia patients who underwent SIL-TAPP repair had a lower probability of trocar site hernia and inferior epigastric vessel injury than female inguinal hernia patients who underwent CL-TAPP repair. In addition, female inguinal hernia patients who underwent SIL-TAPP repair reported a more aesthetically pleasing postoperative abdominal incision. Therefore, SIL-TAPP repair is a better option for the treatment of inguinal hernias in women.

2. *You need to mention if the mesh used in all cases of fixed type or not and what is*

the type and also if the size 15x15 or not.

Reply: Thank you very much for your careful reading and valuable comments. For direct hernias and indirect hernias with hernia sac diameters greater than 4 cm, we usually fix the mesh with a staple gun after placing the mesh, while other types of inguinal hernias usually do not fix the mesh. Moreover, we usually choose a 10 x 15 cm mesh for inguinal hernia repair. Based on your suggestions, we have added more detail to these in the **Surgical techniques** section as follows:

"For direct hernias and indirect hernias with sac diameters greater than 4 cm, we usually fix the mesh with a staple gun after placement, while the mesh is not usually fixed for other types of inguinal hernias."

"A 10 cm x 15 cm mesh was selected for implantation in the preperitoneal cavity to overlie the separation area described above."

3. *You need minor English polishing. Otherwise, I think it deserve to be published. Good luck.*

Reply: You would like us to use more accurate medical English in the manuscript and encourage us to touch up the language of the manuscript. Thank you very much for pointing this out. We couldn't agree more with this comment. In response to your suggestion, the manuscript has been rewritten by professional language editors and native English-speaking medical experts to improve its readability and quality.