Format for ANSWERING REVIEWERS

February 6, 2014

Dear Editor,

Please find enclosed the edited manuscript in Word format (file name: 8839-review.doc).

Title: Role of 3DCT in laparoscopic total gastrectomy with spleen-preserving splenic lymph node dissection

Author: Jia-Bin Wang, Chang-Ming Huang, Chao-Hui Zheng, Ping Li, Jian-Wei Xie, Jian-Xian Lin, Jun Lu

Name of Journal: *World Journal of Gastroenterology*

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The manuscript has been improved according to the suggestions of reviewers:
1 Format has been updated

2 Revision has been made according to the suggestions of the reviewer.

Reviewer's 1

This retrospective comparative study reveals the role of 3D-CT on of the laparoscopic lymphadenectomy of splenic hilar (#10) LN dissection during gastric cancer surgery. The topic is quite important and the surgical technique is quite good, but several issues should be revised.

Major comments：

(1) Although all the data of this study was collected retrospectively, it is not clearly mentioned in the abstract. Please add the word "retrospective" in your abstract.

Response：We have added "retrospective" in the "ABSTRACT".

(2) For which patients, 3D recontruction was performed? Is there any indication of 3D-recontruction of abd. CT in authors' institute? Table 5 shows that 3D-CT was constructed in 22 patients even in the earlier phase (<40 Op), and it was not constructed in 59 patients even in the later phase (>40 Op). Please add some explanation in the manuscript.

Response：The indication to perform 3D recontruction was that patients were preoperatively confirmed as having upper- or middle-third AGC and needed to undergo laparoscopic assisted total gastrectomy with D2 LN dissection, plus spleen-preserving splenic hilar LN dissection. With the help of 3DCT, it enabled surgeons to know the distribution of the splenic vessels preoperatively.

Written consent was given by the patients before undergoing 3DCT because of increasing the medical costs. Therefore, according to patients' wishes, patients were assigned to two groups including group 3DCT and group NO-3DCT. What's more, patients of subgroup were also distributed into the related group according to their wishes. As a result, 3DCT was constructed in 22 patients even in the earlier phase (<40 Op), and it was not constructed in 59 patients even in the later phase (>40 Op). We have added it in the "MATERIALS AND METHODS" and "DISCUSSION".

(3)For the results, only intraoperative data were collected. Please add some postoperative data, such as complication, length of stay, blood transfusion, or mortality, even though they were negative.

Response：The postoperative data, such as complication, length of stay, or postoperative complications, had been showed in Table 3. Meanwhile, two postoperative data, including blood transfusion and postoperative mortality, have been further added in Table 3.

(4) Don't repeat general information of laparoscopic surgery in the introduction and in the discussion. Instead, please add any possible explanations why the difference of intraopeartive outcomes was more profound in the thin patients and in the later phase in the discussion.

Response：The repeated general information of laparoscopic surgery in the discussion was deleted. What's more, we had added the explanations why the difference of intraopeartive outcomes in the thin patients and in the later phase was more profound in the paragraph 4 and paragraph 5 of the "DISCUSSION".

Minor comments

(5) Please check the accuracy of reference list. For exaple, no 17. should be corrected to : "Hur H, Jeon HM, Kim W. Laparoscopic pancreas- and spleen-preserving D2 lymph node dissection in advanced (cT2) upper-third gastric cancer. J Surg Oncol 2008, 97:169-72"

Response：We have checked all of the references according to Pubmed and doi. And the references were right in the revised manuscript.

(6) The surgical technique is quite important, therefore if possible, please add some photos taken during the dissection. (Fog 1 contains only post dissection pictures)

Response：We have added 4 pictures which were taken during the dissection in "Surgical Procedures".

Reviewer's 2

Dear Prof. Chang, I read with vivid interest your paper. I hope it will be accepted for publication.

(1) I'm just wondering whether it's possible for you to specify the statistical test used to calculate the significance of your study, since it could sound strange to get a P=0,000 when means and DS have such values as you report.

Response：In the manuscript, Student's t-tests were used to evaluate continuous variables, and the χ^2 test or Fisher's exact test was used to evaluate the difference in proportions. P values <0.05 were considered statistically significant. We have already described them in "STATISTICAL ANALYSIS". Statistical analyses were performed using the SPSS 18.0 statistical software package, and P value was rounded to be 0.000 when the statistical analysis showed P value less than 0.001 as there was significant difference between two groups. What's more, P=0.000 was usually showed in the paper which was published in WJG, such as "Evaluation of specific fecal protein biochips for the diagnosis of colorectal cancer (2014, Vol.5)", "Portal inflow preservation during portal diversion in small-for-size syndrome (2014, Vol.4)", "Fast-track program vs traditional care in surgery for gastric cancer (2014, Vol.2)".

3 References and typesetting were corrected

Thank you again for publishing our manuscript in the *World Journal of Gastroenterology*.

Sincerely yours,
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