

Answering Reviewers

Reviewer #1

A well-written, retrospective study. As it is known, there are many predisposing factors in the etiology of POPF. It is striking that the patient groups included in the study have similar demographic characteristics. However, it was not stated whether the authors included patients who received preoperative neoadjuvant therapy in this retrospective study they designed. I think that an addition should be made in the article regarding the inclusion or exclusion of this situation. I believe that the value of this anastomosis technique in terms of POPF can be demonstrated more clearly with propensity score matching analysis studies or randomized controlled prospective studies.

Response: Patients who received neoadjuvant therapy before surgery were excluded from the study, which we have stated in the revised manuscript. In addition, due to the limited number of cases in this study, we will summarize more cases in the near future and strive to do a randomized controlled prospective study. Thanks for your valuable advice.

Reviewer #2:

There are several questions:

How was randomization of cases done.

Response: The random number table method had been used for the grouping of this study.

How do authors support the posterior leak predominance rate. There are several modifications of PJ which seem to be very similar to what authors are describing. The authors need to explore all of them and a clear distinction between them and the one which authors are describing needs to be detailed out and the major differences need to be highlighted. Extensive shortening of the text ,especially in the technique section needs to be done. Editing of the

English language needs attention.

Response: Our team found that most POPFs, especially severe cases, occurred at the rear wall of the pancreatic anastomosis. The reasons may be as follows: First, the pancreas is a substantial glandular tissue with a soft, fragile texture. With the exception of the anterior wall, the rear wall and the upper and lower edges have no peritoneal covering. Therefore, an anastomosis on the rear wall is more fragile than an anastomosis on the anterior wall, and it is more prone to cutting injury than an anastomosis on the anterior wall of the pancreas; second, suturing an anastomosis in the rear wall is different from suturing the anterior wall, which is under direct vision, and this leads to a relatively poor grasp of needle depth and density; third, we also found that most of patients have primary pancreatic duct openings that are located in the lower part of the flat ends, and this leads to a rear wall anastomosis being a weak point; furthermore, as the abdominal aorta, celiac trunk, superior mesenteric artery and vein, splenic vein, inferior mesenteric vein and other important great vessels are adjacent to the rear wall of pancreas, a fistula resulting from the rear wall of PJ will undoubtedly lead to disastrous consequences.

Compared to other anastomoses, this anastomosis has the following advantages: first, reducing the occurrence of POPF, including the risk of disastrous bleeding. Three or four U-shaped sutures firmly wrap the rear wall of the pancreas. Even when succus pancreaticus leaks from the rear wall of the first layer, it will be limited to the area between the rear wall of the pancreas and the jejunal serosa and will not leak into the abdominal cavity; second, the indications are widespread. The technique can be adapted to all types of pancreases, no special requirement exists regarding the texture of the pancreas and the diameter of pancreatic ducts; third, it is simple, timesaving and easy to master.

Thanks for your valuable advice.