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Column: Retrospective study

Title: Is fascial closure required for a 12-mm trocar? A comparative study on trocar site hernia with long-term follow up

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Dear Editors:

We thank the reviewers for their insightful comments and suggestions. Below are our responses to the reviewers' concerns. In addition, we have implemented corresponding changes within the manuscript, which are highlighted throughout the text.

Reviewer #1 (Comments to Author):

1- While there was no statistical significance in the occurrence of trocar site hernias (TSH) between the two groups, there were no cases of TSH in the closure group; some consideration must be given to the possibility that the sample size was insufficient to detect possible benefits from the closure.

RESPONSE: We have modified the text to reflect this (p.9, pp.35-37 and p.10, pp.1-2)

2- The manuscript does not mention if there was some form of allocation criteria for the patients to be included in either group, which is important as this could be a significant source of biases.

RESPONSE: The allocation criteria for the patients in both groups depend on surgeon preference We have modified the text to clarify this (p.3, pp.3)

3- Another possible source of bias that should be acknowledged is that different closure techniques were used, according to surgeon preference.

RESPONSE: The detail of closure technique was added to the text to clarify this (p.3, pp.3-6) and we have modified the text to clarify the limitation of this study (p.9, pp.33-34)

Reviewer #2 (Comments to Author):

1- Do the authors conclude from the results obtained that routine closure is not necessary? I do not understand the authors' thinking.

RESPONSE: We concluded that "Routine performance of fascial closure when using a 12-mm trocar may not be needed." because the result from our recent study demonstrated that there was no statistical significance in TSH between closed and open group. However, we have modified the text to reflect this (p.1, pp.30-32)

2- Is it possible to prove non-inferiority in this number of cases with an incidence of 1.1%?

RESPONSE: Our study reports non-significant difference of incidence of trocar site hernia among two groups. However, it is not feasible to prove non-inferiority of non-fascial closure due to inadequate sample size for non-inferiority design.

3- It is stated that the closed group had lower postoperative pain than the non-closed group. Isn't it the other way around?

RESPONSE: From the figure 3, the open group had significantly lower postoperative pain (p=0.018). We have modified the text to correct this (p.7, pp.9)

Reviewer #3 (Comments to Author):

1- The utility and adopted protocol for cross sectional imaging needs further elaboration. Apart from cases of colon cancer for which a specific protocol is adopted for follow up the

utility of cross sectional imaging in follow up and screening for diagnosing tracer site hernias needs to be deliberated upon.

RESPONSE: This recent study was specific designed in minimally invasive colorectal surgery for colorectal cancer patients. Therefore, cross sectional imaging is one of the surveillance tools. However, we excluded128 patients with no cross-sectional imaging from the study because all of these patients underwent only ultrasonography. Figure 1

2- Current literature still supports routine closure of all tracer sites > 10 mm. Routine closure of non midline, non bladed tracer sites can be optional but whether it can be totally omitted needs to be further debated upon.

RESPONSE: We agreed with reviewer comments. We have modified the text to reflect this ((p.9, pp.35-37 and p.10, pp.1-2).

We thank the editorial board for considering our work, and we thank the reviewers for their help in improving it. We hope you will find this revised manuscript suitable for publication in World Journal of Clinical Cases.

Sincerely,

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