

Dear Editors,

We would like to thank you and the reviewers for their valuable feedback on our article on the novel surgical procedure for early-stage esophagogastric junction gastric cancer. We appreciate reviewers' positive comments on the novelty of our procedure and its potential clinical value. We have carefully considered their concerns and have addressed them below. We hope that our responses have addressed those concerns satisfactorily, and we look forward to your feedback on the revised manuscript.

Sincerely,

Li-Qun Pang

Reviewer #1:

The authors demonstrated a novel surgical procedure for early stage esophagogastric junction gastric cancer. Though this original article was well written and EGAA seems unique, there are some concern about this operation. Major point: 1. The patients who underwent EGAA was only 10 patients. This population is not enough to evaluate the surgical effectiveness of EGAA. 2. The authors should state evaluation of endoscopic findings as to the two patients who underwent reflux esophagitis after proximal gastrectomy according to LA classification. In addition, when did the symptom of GERD begin after EGAA? If it is possible, please show us the endoscopic pictures of these two patients after EGAA. 3. After surgery of EGAA, upper gastroenterography showed 50% of patients were suffering reflux. I think this percentage is too high as compared to proximal gastrectomy using Kamikawa method in Japan. The authors should explain about this point. Minor point: 1. I would like to know postoperative body weight loss of the patients who underwent EGAA. Please add postoperative BMI in Table1.

Major points:

1. The number of patients who underwent EGAA was only 10, and this population is not sufficient to evaluate the surgical effectiveness of EGAA.

Response: We agree that the number is limited. However, due to the limited number of patients who met the inclusion criteria for this innovative surgical procedure at our hospital, we were only able to enroll 10 patients in this study. Till now, we have since performed 13 cases of proximal gastrectomy with esophagus-gastric asymmetric anastomosis (performed laparoscopically) and now we have included the additional 3 cases in the revised manuscript. We hope to introduce this technique to other hospitals and surgeons through your esteemed journal to conduct multi-center collaborative research to better evaluate the anti-reflux effect and clinical value of this innovative surgical procedure.

2. The authors should state the evaluation of endoscopic findings for the two patients who underwent reflux esophagitis after proximal gastrectomy according to the LA classification. In addition, when did the symptom of GERD begin after EGAA? If possible, please show us the endoscopic pictures of these two patients after EGAA.

Response: We apologize for the lack of information on the endoscopic findings of the two patients who developed reflux esophagitis after EGAA. It would be useful to evaluate their endoscopic appearance based on the LA classification system. Additionally, it is informative to note that GERD symptoms occurred around 2 weeks post-surgery in our 13 EGAA cases, but were relieved with proton pump inhibitor treatment. Endoscopic examination at 3 months post-surgery did not reveal any significant reflux esophagitis.

3. After surgery of EGAA, upper gastroenterography showed 50% of patients were suffering reflux. This percentage is too high compared to proximal

gastrectomy using the Kamikawa method in Japan. The authors should explain this point.

Response: Regarding the incidence of post-operative reflux among patients who underwent the EGAA procedure, we want to point out that during our clinical practice, we continuously explored, made progress, and gradually improved this latest technology. In the first two patients who underwent the EGAA procedure for cardia cancer, significant reflux occurred. However, all 11 patients who followed had excellent anti-reflux effects after surgery, especially the last 8 cases, whose reflux was absent even when the patient was placed in the supine position for gastrointestinal imaging studies. We attribute the good post-operative results to the correction of technical shortcomings by accumulating sufficient experience over time. As such, please be assured that the EGAA design for anti-reflux surgical methods is reliable, so as long as the surgery meets the EGAA design standards, good anti-reflux effects can be achieved, even if there is an asymmetric connection between a short remaining esophagus and the narrow tubular stomach (4-5 CM) without constriction or swallowing difficulties.

Minor point:

1. I would like to know the postoperative body weight loss of the patients who underwent EGAA. Please add postoperative BMI in Table 1.

Response: We appreciate your suggestion and have included the postoperative BMI and body weight loss of the patients who underwent EGAA in Table 1. Our follow-up period ranged from 2-19 months and out of the 13 EGAA patients, 4 had decreased body weight while one of them underwent cholecystectomy at 6 months after initially undergoing EGAA. Additionally, 5 patients did not experience significant changes in weight, while 4 actually exhibited an increase in BMI.

Reviewer #2:

Appreciating gracious efforts of all authors in the production of this manuscript and endeavours to negate to free of the well-established drawbacks of conventional oesophagogastrostomy. 1. Aside grammatical errors, I would suggest authours to use terminolgy either plasmomuscular or seromuscular. In the main body of the manuscript, they have used plasmomuscular whil in the diagram (Fig 1) , seromuscular. 2. Consider adding few cross-sectional oral contrast CT scan especially post surgery, to highlight the appearances asymmetrical valve created as a result of surgery + oral contrast stroke barium x-ray if available. The technique is novel and sheds new way of limiting reflux induced morbidity, that is common following the conventional anastomosis. In my opinion, further studies are needed to confirm the findings, aside difficult to sustain quality outcomes with questionable transferrable skills about this new surgical technique.

Thank you for your constructive suggestions and feedback. Here are our responses to your points:

1. Aside grammatical errors, I would suggest authours to use terminolgy either plasmomuscular or seromuscular. In the main body of the manuscript, they have used plasmomuscular whil in the diagram (Fig 1) , seromuscular.

Response: We appreciate your suggestion and we will ensure that we use the term "plasmomuscular" consistently in the text and in Fig. 1.

2. Consider adding few cross-sectional oral contrast CT scan especially post surgery, to highlight the appearances asymmetrical valve created as a result of surgery + oral contrast stroke barium x-ray if available

Response: While we acknowledge the potential value of cross-sectional oral contrast CT scans, we currently use CO₂ gas to visualize the structure of the reconstructed valve. CO₂ gas allows us to observe any leaks at the anastomosis site, and the residual gas and contrast material in the esophagus can be visualized by CT to evaluate the valve

structure. Oral contrast agents such as barium cannot adequately fill the residual stomach and esophagus, and thus, they may not be the best option for evaluating the structure and closure status of the valve. We have found that our approach has been effective in evaluating the valve function and we will consider incorporating additional imaging modalities in future studies.

3. The technique is novel and sheds new way of limiting reflux induced morbidity, that is common following the conventional anastomosis. In my opinion, further studies are needed to confirm the findings, aside difficult to sustain quality outcomes with questionable transferrable skills about this new surgical technique.

Response: We appreciate your comments on the novelty and potential benefits of the EGAA surgical technique. We have observed promising results in the 13 cases of gastroesophageal junction adenocarcinoma and 12 cases of esophageal cancer that we have performed. While there were two cases of reflux in the early stages of the gastroesophageal junction adenocarcinoma cases, all other patients had no symptoms or signs of reflux. However, we agree that further studies are necessary to confirm our findings and to evaluate the efficacy and safety of the EGAA technique. We also believe that the EGAA technique is not difficult to perform and can be easily adopted by surgeons with basic laparoscopic suturing skills, with a minimal increase in patient risk. In our experience, the average suturing time for the anastomosis site in the 12 cases of esophageal cancer was only around 25 minutes, and there were no cases of reflux after surgery. We will continue to evaluate the technique and work towards making it more widely available to patients.