

Dear editors and reviewers:

Thank you for your letter and for the reviewers' comments concerning our manuscript entitled "Safety and feasibility of modified duct-to-mucosa pancreaticojejunostomy during pancreatoduodenectomy: A retrospective cohort study" (ID:85635). Those comments are all valuable and very helpful for revising and improving our paper, as well as giving important guiding significance to our research. We have studied the comments carefully and have made corrections that we hope will be met with approval. The revised portions are marked in red in the paper. The main corrections in the paper and the responses to the reviewers' comments are as follows:

Responses to the reviewer's comments:

Reviewer #1:

1. **Response to comment:** Pancreaticoduodenectomy (PD)-Abstract-please use the same term throughout the text: pancreatoduodenectomy or pancreaticoduodenectomy. I think, the first one is better. major risk factors for postoperative pancreatic fistula (POPF) development (Abstract)-please use Abbreviation only. Core tip: please use abbreviations only where appropriate. Pancreaticoduodenectomy (PD) (Introduction) - see the comment above.

Response: As the Reviewer suggested, the word "pancreatoduodenectomy" might be more appropriate, and

abbreviations should be used appropriately. We have made corrections according to the Reviewer's comments.

2. **Response to comment:** 1 case of grade C POPF in the modified pancreaticojejunostomy group. However, in the traditional group, the number of cases at each grade was 20, 7 and 3, respectively. Obviously, modified pancreaticojejunostomy might attenuate POPF severity based on the comparison results (Results) - please use PJ but not full term (twice). risk factors for POPF included pancreaticojejunostomy method (Discussion) - see comment above. development (Discussion) - development is right. binding pancreaticojejunostomy in the prevention of postoperative complications and death[22]. While Ratnayake's research favored duct-to-mucosa pancreaticogastrostomy[23] (Discussion) - please use PJ and PG.

Response: We have used abbreviations where appropriate according to the Reviewer's comments.

3. **Response to comment:** Topal B, Fieuws S, Aerts R, Weerts J, Feryn T, Roeyen G, Bertrand C, Hubert C, Janssens M, Closset J, Belgian Section of H, Pancreatic S. (Ref. 17) - please correct the Section name (as listed in PubMed).

Response: We have corrected the reference entries based on the information listed in PubMed.

4. **Response to comment:** Finally, I think that it would be very good if you included in the analysis (and mentioned in the text) the percentage of patients who underwent preoperative biliary drainage to relieve jaundice. The results of recent studies show that this is a significant risk factor for complications.

Response: Considering the Reviewer's suggestion, we have included and analyzed the data about preoperative biliary drainage. However, our results did not indicate that this risk factor was significantly associated with POPF.

Reviewer #2:

1. **Response to comment:** In the method of modified duct-to-mucosa PJ, the posterior wall of the pancreatic duct and the jejunal mucosa were continuously sutured with three to four 4-0 Prolene sutures. In your description, you do not perform any suture for anterior wall of the pancreatic duct and the jejunal mucosa after inserting the stent. Is this correct?

Response: The traditional method of pancreatic duct suturing (a total of four sutures of the anterior and posterior walls) is relatively reliable, but the operating steps are cumbersome and time-consuming.

Therefore, to overcome the above shortcomings, we designed a "semicontact continuous anastomosis technique". Although we do not suture the anterior wall of the pancreatic duct in this technique, the depth of suturing the pancreatic stump on the anterior side is relatively deeper to reduce the possibility of pancreatic fistula. In addition, some patients have very thin pancreatic ducts, which makes it difficult to suture the anterior wall, and there is a possibility of later obstruction after suturing. We are not sure if this is the best method, but our single-center research results confirm that the risk of postoperative pancreatic fistula in patients is indeed reduced compared to traditional methods. Also, there are relatively fewer perioperative complications. Although further multicenter research is needed to confirm the effectiveness of our method, we believe that this innovation is adapted to the development characteristics of future minimally invasive procedures, robotic surgery and other surgical operations.

2. **Response to comment:** Where and how were drains inserted at the site of PJ anastomosis?

Response: We have rewritten this part according to the Reviewer's suggestion. The routine procedures for placing the pancreatic stent tube were as follows: after suturing the posterior wall of the pancreatic stump, a right-sized stent tube (8-10 cm in length) with side holes was inserted 3-5 cm into the pancreatic duct, and the other end was placed

approximately 5 cm into the small intestine. Then, a stitch was placed to fix and suture the stent tube on the posterior side of the pancreas.

3. **Response to comment:** In the results, “As shown in Table 1, POPF development” should be “As shown in Table 2, POPF development”, because Table 2 is univariate and multivariate analysis.

Response: As the Reviewer suggested, Table 2 shows the univariate and multivariate analyses. We have made corrections as suggested.

4. **Response to comment:** Table 1 is not described in the result section.

Response: Considering the Reviewer’s suggestion, we have described information in Table 1 in this first part of the results section.

5. **Response to comment:** In the result, Table 2 does not match the description of the text, because Table 2 shows univariate and multivariate regression analysis. Anyway, Table number does not match the result description. Table 2 may be missing.

Response: We are very sorry for our negligence in providing incomplete results. We have added information about Table 3, which shows the differences between traditional end-to-side invagination PJ and modified duct-to-mucosa PJ in detail.