

Dear Editors and Reviewers:

Thank you for your letter and for the reviewers' comments concerning our manuscript entitled "Pylorus-preserving gastrectomy for early gastric cancer" (NO. 91077). Those comments are valuable and helpful for revising and improving our paper, as well as the important guiding significance to our researches. We have studied comments carefully and have made correction which we hope meet with approval. Revised portion are marked in red in the paper. The main corrections in the paper and the responds to the reviewer's comments are as flowing:

Reviewer #1:

Since most T1aN0M0 cases undergo endoscopic mucosal resection, the indications of PPG are mainly T1aN0M0 cases which are not suitable for endoscopic resection and T1bN0M0 cases. It can also be considered as an additive surgery after endoscopic resection. --Please give references.

According to Japanese gastric cancer treatment guidelines, most T1aN0M0 cases undergo endoscopic mucosal resection. Pylorus-preserving gastrectomy has been recommended as a treatment route for middle-third T1N0M0 gastric cancer with a distal tumor border at least 4 cm proximal to the pylorus. We have added a reference in the manuscript.

[9] Japanese Gastric Cancer Association. Japanese gastric cancer treatment guidelines 2018 (5th edition). *Gastric Cancer* 2021; 24(1): 1-21.

From the text: Lymph node dissection --It would be better for the readers if you gave a figure and explained it with reference to it.

We add Figure.1 in the manuscript to explain lymph node dissection in pylorus-preserving gastrectomy.

From the text: Anastomosis method --It would be better to explain open, laparoscopic, and robotic operations separately.

Thank you for your comments. The open surgery of pylorus-preserving gastrectomy is rarely performed. Although several studies on robotic surgery for gastric cancer have been published, studies focused on robot pylorus-preserving gastrectomy are rare. For most robots and laparoscopic pylorus-preserving gastrectomy, anastomosis is still achieved through auxiliary incisions. Therefore, we did not discuss separately. Although many laparoscopic intracorporeal anastomosis methods have been adopted, extracorporeal handsewn anastomosis remains the most popular method.

From the text: It is hoped that the ongoing multicenter randomized controlled trial KLASS-04 will settle the question of the advantages of PPG to DG in terms of oncological safety and functional benefits. The first results of this study can be mentioned.

Thank you for your comments. The short-term outcomes of KLASS-04 showed that the postoperative complications were comparable between laparoscopic pylorus-preserving gastrectomy and laparoscopic distal gastrectomy. The long-term outcomes of oncological safety and functional benefits have not been published.

The preservation of pyloric function has complicated the technicalities of PPG and suggested the potential risks associated with incomplete lymph node dissection. The precise determination of functional benefits, oncological safety, technique standardization and the clarification of complications have not been strictly addressed. It is also not fully understood whether patients benefit from PPG if they suffer gastric stasis, or whether PPG for EGC increases the risk of secondary gastric cancer. This concluding section should include positive findings rather than negative and inconclusive results. It would help if you also considered including positive findings.

Considering the Reviewer's suggestion, we have added corresponding content in the manuscript.