

Dear editor,

We're grateful for the time and insightful comments of the reviewers.

Reviewer #1:

1. Add a paragraph in review about single port vs multiport robotic cholecystectomy- advantage and disadvantages other than ergonomics and technical part (not compared to lap cholecystectomy)

Although there is no concrete evidence which compares single-port versus multi-port robotic cholecystectomy operations' advantages and disadvantages other than ergonomics and technical parts, I strongly agree with Reviewer 1 that this is a very important point to elaborate. We inserted the below paragraph and reference to our manuscript.

Sun et al. published a systematic review and meta-analysis in 2018, which compared single-site robotic cholecystectomy and multi-port laparoscopic cholecystectomy surgeries. They concluded that the risk of incisional hernia and the high cost should be considered when performing SSRC. But indeed, their main conclusion is that so far, the advantages and disadvantages of single-site robotic cholecystectomy (SSRC) still have not been extensively studied, and we need more high-quality studies and data to be able to comment on robot-assisted cholecystectomy operations. We even don't have concrete evidence which compares single-port versus multi-port robotic cholecystectomy operations' advantages and disadvantages other than ergonomics and technical parts. More high-quality studies are also needed for more complex gallbladder diseases.

Sun N, Zhang J, Zhang C, Shi Y. Single-site robotic cholecystectomy versus multi-port laparoscopic cholecystectomy: A systematic review and meta-analysis. *Am J Surg.* 2018 Dec;216(6):1205-1211. doi: 10.1016/j.amjsurg.2018.04.018. Epub 2018 May 22. PMID: 29866396

2. Difference in size of skin incision in SPLC and SPRC.

In our clinical practice, we use almost the same incision for SPLC and SPRC.

3. Explain the higher incidence (60%) incisional hernia? Was any measures taken to minimize in recent years as this was an experience between 2013-2021.

60 % is indeed the incidence of umbilical hernia before the surgery not the incisional hernia. But this is another important point, and to avoid a high rate of incisional hernia we use more "graft reinforcement" in the recent years.

4. Add one table comparing your own data of laparoscopic cholecystectomy (single/ multiport) of last 40 patients .

This comment is also highly appreciated, and we added a paragraph and a table (Table 2) for our 40 consecutive multiport laparoscopic cholecystectomies performed in the last six

months.

We also evaluated our 40 consecutive multiport laparoscopic cholecystectomies performed in the last six months to guide us in evaluating the results of our study. The average age is 45.5. Fifteen of the patients were female and 25 were male. Perioperative bleeding was minimal. Complications at the level of Dindo Clavien 1 (two diarrhea, one pain) developed in three patients postoperatively. The length of stay in the hospital was 1 day and there was no re-hospitalization. Drains were used in four patients. One patient had an umbilical hernia. No grafts were used in any of the patients. A single analgesic containing paracetamol was used postoperatively in 23 of the patients. The mean BMI was 28.7 kg/m² and the mean operative time was 54 minutes. 14 patients had ASA 1, 23 patients had ASA 2 and 3 patients had ASA 3. 13 patients were operated on for acute cholecystitis.

Reviewer #2:

1- Although you clearly mentioned the fact that an economic comparison was not a primary goal of the paper it would definitely add even more value to the study since nowadays, with all major surgical options for gallbladder surgery being mature enough for clinical widespread, a cost-to-benefit ratio will definitely be a major determining point in choosing the most balanced method for surgical approach in this class of diagnosis.

You are absolutely right and we did insert our recent costs to the manuscript.

The mean cost was \$6658.9 for robotic single-port cholecystectomy and \$2439.1 for multiport laparoscopic cholecystectomy.

2- IN ABSTRACT -> METHODS Page 2, Line 20 , Column 66 [...] cholelithiasis [...] Please specify whether the inclusion diagnosis included both vesicular lithiasis and/or common bile duct lithiasis as this class of diagnosis might suggest. Later in the paper you only specify gallbladder lithiasis, so a clarification at this point is in order.

Thank you, perfect point and corrected.

3- IN MAIN TEXT -> METHODS Page 5, Line 3, Column 29 [...] gallstones [...] Please provide some information to clarify the type of clinical diagnosis and classification. Were all patients asymptomatic? Were all surgeries performed in patients with no clinical and imaging modifications? Was acute or chronic gallbladder inflammation present? This might support the excellent results of having no complications at all during your series of SPRC, however limit the span of the conclusion that SPRC can be safer and with better results than other methods.

This important is also elaborated.

No distinction was made between patients with or without symptoms. Patients with acute cholecystitis or suspected malignancy were not included in the group.

4- IN MAIN TEXT -> RESULTS Page 5, Line 8, Column 55 [...] technique similar to LC [...] Without going into technical details of the robotic approach, please specify whether your surgical strategy for dissection included achieving the Strasberg critical view of safety, a rule the most of the experienced surgeons that perform LC abide by. This can further clarify that the view achieved by SPRC is the same or better than LC.

We are indebted for this crucial detail, and it was addressed.

To reduce the risk of bile duct injuries and to avoid complications due to anatomical alterations, we used "Critical View of Safety" technic introduced by Strasberg in all our SPRC surgeries. Admittedly the view achieved by SPRC is usually better than laparoscopy.

Sgaramella LI, Gurrado A, Pasculli A, et al. The critical view of safety during laparoscopic cholecystectomy: Strasberg Yes or No? An Italian Multicentre study. Surg Endosc. 2021; 35(7): 3698–3708. DOI: [10.1007/s00464-020-07852-6](https://doi.org/10.1007/s00464-020-07852-6) PMID: [32780231](https://pubmed.ncbi.nlm.nih.gov/32780231/)

5- Page 5, Line 29, Column 54 [...] graft reinforcement [...] Please specify what type of graft reinforcement surgical method you considered for the abdominal wall reconstruction. Was it mesh? What type and what method of mesh placing?

We added the technical details and this version is definitely better.

We used a prolene graft for fascia closure reinforcement. After the fascial defect was primarily closed, a proper size prolene graft was placed as an on-lay, and the graft was fixed with interrupted non-absorbable sutures.