

**Reviewer's code:** 02691280

**SPECIFIC COMMENTS TO AUTHORS**

Despite the declared limitations, that I personally share, I find this little study pretty interesting because its proposing a method that should be used on human cadaveric specimens, with different suture configurations. I mean, it is a quite simple and effective way to demonstrate contact area effective surface for rotator cuff repairs and subsequent studies should be aimed at checking in human samples how not only double row perform. References should be reordered, but besides that and some minor language polishing I fell like it is worth publishing.

**Answer:** No comments to be revised.

**Reviewer's code:** 01220036

**SPECIFIC COMMENTS TO AUTHORS**

accepted

**Answer:** No comments to be revised.

**Reviewer's code:** 02691156

**SPECIFIC COMMENTS TO AUTHORS**

The title is referring directly to the problem at hand. The abstract is sufficient. Introduction is also sufficient and explanatory. Methods The 24 porcine shoulders were divided into 3 groups of 8 specimens. The double-row repair performed for all 3 groups. One pair of sutures from each medial row suture anchor was crossed with the corresponding pair in the other medial anchor and, together with the uncrossed pair of sutures, secured to 1 lateral row knotless anchor each. All dissections and repairs were carried out by a single surgeon. Results showed that there is no statistically significant difference between the mean contact areas of the treatment groups. Discussion You

discussed the hypothesis that with a larger footprint contact area, more tendon fibres are exposed to bone, improving healing potential. The double-row repair has been described in literature to be superior in restoring footprint dimensions as compared to the single-row repair. While many studies have looked at the contact area between single versus double-row repairs, few or no studies to authors' knowledge have analysed the contact area characteristics between double-row repairs performed using 3 and 4-suture anchors. In your institution, the cost of a suture anchor ranges between S\$600 to S\$900. By using 1 less anchor per patient (25% savings in terms of cost), it appears that same result may be achieved. You conclude that "[...] Our study showed that there is no statistical difference in tendon-to-bone contact area when using a 3 or 4-suture anchor construct. This may potentially translate to shorter surgical times and lower healthcare costs with the use of fewer anchors without compromising tendon-to-bone healing of rotator cuff tears." Limitation of the study: According to the authors among the limitations of the present study are: The small sample size. The use of a porcine cadaveric model is still disadvantageous as compared to using a human cadaveric model due to the difference in anatomy. They did not make use of a tensiometer to gauge the tension of the repairs. Fresh tendons tears were used, which may not replicate the quality of the tendons in chronic tears. References: 21 papers are included supporting your investigation.

**Answer:** The manuscript has been revised accordingly.