First reviewer

Minor revision

1. in the results section Authors report a 70% early postoperative complication rate. In table 2 Authors report early complications in eight out of ten patients (80% rate) and a 30% late complication rate. Please explane or correct;

A1: It was a mistake. I have corrected it into the result section.

2. In the discussion section Authors mention the possibility of severe and even life-threatening intraoperative bleeding during the sacral step of the procedure. In the methods section Authors write that notwithstanding several Authors prefer to make a preventive internal iliac vessels ligature, they never performed it in the reported cases. Authors should better explane why they avoided the ligature of hipogastric vessels considering the high risk of intraoperative bleeding

A2: Internal iliac vessels ligature was not routinely performed in our series because we believe that this approach is needed only in upper sacral resection due to an higher risk of local bleeding. Furthermore, ligation of such an important vascular pedicle could increase the risk of skin leakage and perineal infection.

3. Furthermore, notwithstanding Authors collected data on blood transfusions during surgery in their electronic database, no mention about this parameter is done in the results section. Also, it would have been interesting knowing data on the intraoperative blood loss.

A3. Data regarding blood transfusion are already reported in the paper. Mean intraoperative blood loss was 1750 ml (range, 200-6800 ml).

Second reviewer

Major comments

1. Not appropriate to use percentage when describing 10 cases only.

A1. I have recognized your advice and I have deleted a lot of percentage in the paper.

2. The authors have commented on recurrence rate of 33 percent in introduction vs <10% in discussion. They should comment that the high recurrence rates were before the TME era.

A2. The recurrence rates (33% and 10%) are both reported in discussion, highlighting the role of TME in reducing the recurrence rate.

3.Was any adjuvant treatment given after ASR?

A3. Adjuvant chemotherapy was performed in 2 patients under suggestion of medical oncologists due to local extension of disease. I have added this information in result section.

4. Was there any standard specific reason for not offering Neoadjuvant treatment for the 4 cases of stage 3 and 4?

A4. No patient received a pre-surgical neo-adjuvant therapy. In the pT3 cases this was mainly due to the bad clinical status of the patients at the moment of diagnosis (occluding or bleeding lesions)

5. The authors also need to discuss that 5 cases with initial stage 1 had recurrence. Was this related to other unfovarobale tumor factors.

A5. In our case series, all stage I reported were high grade tumors with associated vascular and perienural invasion.

6. The total number of Anterior resections done during this period, number of local recurrences and whether any were not found suitable for surgery and if any underwent other procedures for pelvic recurrence such as exenteration.

A6. Between 2005 and 2013 in our Unit 1324 patients affected with rectal cancer were treated with different surgical procedures. 162 (12.2%) recurred in the pelvis in a period ranging from 10 to 38 months after surgery. 154 of these were considered candidates to a second surgical salvage approach.

7. The authors have not specified how many patients required a flap for closing the perineal defect.

A7. In our experience, a flap was performed in two cases (2 and 7).

Minor points

1. Background is required in abstract section.

A1. I have added it.

2. Add a radiological image of recurrence.

A2. I have added it.

Third reviewer

1. Add more details about primary tuomurs like distance from anal verge and why neoadjuvant CT-RT was not performed in indicate cases ? All patients received a postop CT-RT, but half of them were T2N0 ?! Please clarify this issue.

A1. Median distance from anal verge was 6 cm (range, 3-11). No patient received a pre-surgical neo-adjuvant therapy. In the pT3 cases this was mainly due to the bad clinical status of the patients at the moment of diagnosis (occluding or bleeding lesions). All patients with histological nodal involvement or diffusion of disease into the perirectal fat received a post-operative CT-RT treatment in accordance to standardized schedules.

2. The interval to recurrence from first procedure is not specified, please describe it.

A2. This information is already reported in Table 2 as disease free survival.

3. In 6 patients surgery was performed after new CT-RT, describe the criteria for such a decision.

A3. New CT-RT was performed under suggestion of medical oncologists due to local extension of disease and long time occurred between the end of adjuvant treatment and the time of recurrence diagnosis.

4. Since sacral invasion was present in half of the cases, in your opinion it could have been spared in some cases?

A4. As already reported in literature, sacral resection is indicated both when bone invasion is preoperative present and when it is highly probable.

5. It would be interesting to know which percentage represent this group of reoperated patients respect to the overall recurrence rates.

A5. Between 2005 and 2013 in our Unit 1324 patients affected with rectal cancer were treated with different surgical procedures. 162 (12.2%) recurred in the pelvis in a period ranging from 10 to 38 months after surgery. 154 of these were considered candidates to a second surgical salvage approach.

Minor issue (M and M): clarify the sentence starting with "Indications for ASR"

A. I have modified the sentence.

Fourth reviewer

No revision requested