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Title: Modified binding pancreaticogastrostomy versus modified Blumgart pancreaticojejunostomy after laparoscopic pancreaticoduodenectomy for pancreatic or periampullary tumors
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<table>
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<tr>
<th>Scientific quality</th>
<th>[ ] Grade A: Excellent</th>
<th>[ ] Grade B: Very good</th>
<th>[Y] Grade C: Good</th>
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<td>[ ] Grade D: Fair</td>
<td>[ ] Grade E: Do not publish</td>
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<th>Language quality</th>
<th>[Y] Grade A: Priority publishing</th>
<th>[ ] Grade B: Minor language polishing</th>
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<td>[ ] Grade C: A great deal of language polishing</td>
<td>[ ] Grade D: Rejection</td>
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<th>Conclusion</th>
<th>[ ] Accept (High priority)</th>
<th>[ ] Accept (General priority)</th>
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<td>[ ] Minor revision</td>
<td>[ ] Major revision</td>
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SPECIFIC COMMENTS TO AUTHORS

Thank you for the opportunity to review this study. Kindly find my comments below.

1. The study compares two types of management of the pancreatic stump: PG vs PJ in laparoscopy during the learning curve. All procedures were performed by one surgeon. PJ type had higher rates of POPF-B/C and PG of PPH.  

2. When patients were eligible for PG or Blumgart PJ, both had variations of the original technique in order to achieve a pure laparoscopic procedure. Hence, it is important to address the following: 

   a. The idea of the Blumgart PJ is to lower the shear forces along the cut surface of the pancreas. This is achieved by covering the transection surface with the jejunal wall. This is important as the patients with PJ in this study had only 2 stitches on each side of the pancreatic duct. Although the use of stents mitigated POPF’s the clear benefit seems to be obtained from external stents. This has not been specified in the paper. Hence, the variation in the Blumgart technique is a confounder. The PG also has a variation but does not seem to have added potential confounders. Accordingly, as reported in the literature, PPH is an important complication in this type of reconstruction. 

   b. The authors address that no mortality was recorded. However, was this in-hospital mortality, 30-day or 90-day mortality? In HPB surgery a 90-d follow-up is a more precise measure to report this outcome. 

   c. Regarding definitions, what FRS was used? 

   d. What was the outcome of the patients with PJ or PG who were not included in the study? 

   e. When expressing the p-value, it is noteworthy that they are not 0 or 1, they could get close to those values and despite the statistic package, it is better to notate them as >0.999 or <0.0001.
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Scientific quality
[ ] Grade A: Excellent  [ ] Grade B: Very good  [ Y] Grade C: Good
[ ] Grade D: Fair  [ ] Grade E: Do not publish

Language quality
[ Y] Grade A: Priority publishing  [ ] Grade B: Minor language polishing
[ ] Grade C: A great deal of language polishing  [ ] Grade D: Rejection

Conclusion
[ ] Accept (High priority)  [ Y] Accept (General priority)
[ ] Minor revision  [ ] Major revision  [ ] Rejection
SPECIFIC COMMENTS TO AUTHORS
The manuscript is quiete original, reporting a discrete cohort of patients treated by an old well-known technique, applied to laparoscopy. The finding are very honest, reporting some improved results (reduced POPF) at the price of increased bleedings. Therefore, I would like to suggest to better stress a couple of issues in the discussion. First, laparoscopic technique should not modify the evidence of surgery in order to reduce technical difficulties. Therefore, the ongoing Literature does not recommend pancreaticogastrostomy as a routine.