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Editor-in-Chief
World Journal of Gastrointestinal Surgery

20th January 2023

Dear Editors,

Thank you for reviewing our manuscript, titled "Surgical Management of High-Grade Pancreatic Injuries: Insights from a High-volume Pancreaticobiliary Specialty Unit" (Manuscript Number: 82048).

We would like to thank the editorial committee and the reviewers for their helpful comments on the manuscript, which we have responded to in point form below.

We hope you will find this revised manuscript suitable for publication in *World Journal of Gastrointestinal Surgery*.

Sincerely,

Juanita N Chui
On behalf of the authors
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Reviewer 1.

Congratulations to the authors for reporting their experience of about 20 years with a not fair number of cases. However, the article is simply a case series and although it gives us information on the course of these patients, it does not discuss the current literature much.

Some points to change:

- Specify how the damage control Surgery was performed for unstable patients

    - Only one patient required damage control surgery:
        - Patient 3 in Table 2a had major vascular trauma requiring distal thoracic aortic cross clamp and left renal artery embolization. Due to ongoing coagulopathy and haemodynamic instability the decision was made to resuscitate the patient prior to undertaking definitive pancreatic resection. Four quadrant packing was performed, and a surgical drain left in-situ, at the site of pancreatic transection.
        - The patient was stabilised in ICU with ongoing MTP. There were two returns to theatre as part of damage control, for 1) exploration of chest wall bleeding, 2) for repair of bowel injury. Definitive pancreatic resection was performed 72 hours after initial operation, where patient underwent a distal pancreatectomy and splenectomy.
        - This has been added to the details in *Table 2b* to specify the above.
    - All other patients were stabilised with pre and intraoperative resuscitation and proceeded to definitive intervention with single staged pancreatic resection.

- I would discuss even better the concept of one stage vs double stage PD (only a meta-analysis reported)

    - Thank you for your suggestion. The manuscript has been revised accordingly.

- No case was a pious and biliary exclusion performed good cases of proximal pancreatic trauma? We also need to discuss well what the literature says about it being a very important DMS method

    - The authors have interpreted Reviewer 1's comment to relate to pyloric exclusion.
    - This study reports on high-grade pancreatic injuries. All patients who were managed for proximal pancreatic and duodenal injuries proceeded to pancreaticoduodenectomy. Isolated duodenal injuries were excluded. As such, duodenal repair using pyloric exclusion was not addressed, although the authors acknowledge its role in the management of complex duodenal injuries.

Reviewer 2.

In this study, the Authors presens a single-centre series of patients undergoing operative management for pancreatic trauma in Australia. Over a twenty-year period, 14 patients underwent pancreatic resection for high-grade injurie. . Nine underwent distal pancreatectomy and 5 underwent pancreaticoduodenectomys. Three patients developed clinically relevant pancreatic fistulas and there was one in-hospital mortality secondary to multi-organ failure. The Authors demonstrate that for high-grade pancreaticoduodenal injuries, with adequate expertise supported by modern techniques, resection and reconstruction can be safely achieved with favourable outcomes by high-volume specialist pancreatic surgeons. Obviously, this type of surgery is to be reserved for centers with high volume HPB surgery. The aper is interesting and well-written. I congratulate with the Authors for the excellent results obtained after this challenging surgery.

I have some points to discuss.

- This is a retrospective study covering a long period of time: is there a change of treatment or diagnostic approach during these 20 years?
    - The discussion has been expanded to address the growing use of minimally invasive intervention in contemporary practice, including endovascular control of traumatic haemorrhage and endoscopic management of pancreatic duct disruption.

- The study reports all patients who underwent surgery for pancreatic trauma. I think it was observed also patients which did not undergo surgery. What about these patients? - Is there a role of endoscopic approach for these patients?
    - Patients who were conservatively managed for pancreatic trauma were not included in this case series. This study reports only on patients sustaining high grade pancreatic trauma proceeding to surgical intervention. The aim of this retrospective study was to conduct a focused examination on these rare and severe presentations.
    - The growing use of interventional endoscopy for the management of pancreatic trauma is emphasized in the revised manuscript, as outlined above.

- Information about the follow-up of operated patients may be interesting.
    - The authors agree with Reviewer 2's comment. Unfortunately, long-term follow up was not available for a retrospective analysis. This has been addressed in our revised manuscript to appropriately acknowledge this limitation.