Dear editor,

The comments of you and the reviewers were highly insightful and enabled us to greatly improve the quality of our manuscript. In the following pages are our point-by-point responses to each of the comments of the reviewers. In addition, the specific modification content is also marked in yellow in the manuscript.

1.The authors should consider including laparoscopic surgery for CD or the safety, feasibility and short-term efficacy of laparoscopic enterectomy for CD in the title as highlighted in core tip.

Answer： We have rewritten thie core tip.

2.Does pre-operative US scan change the first laparoscopic port insertion in virgin abdomen or in simple CD versus complex CD?

Answer： To determine the first trocar position in patients with complex CD (Fig. 3), preoperative abdominal US is useful for evaluating the degree and location of abdominal adhesions, as well as the range of diseased bowel. In general, we will choose the area where the activity between the abdominal wall and viscera is greater than 30 mm to insert the first trocar.

3.Inclusion criteria 3).Please explain the exclusion criteria 1) a history of confounding results or other additional risks, what are the confounding and additional risks?

Answer： We have removed this condition.

4.Under surgical procedure, how did the surgeon select cases for laparotomy as a routine procedure?

Answer： The patients are considered for laparotomy incleded: 1. The patient suffered from severe cardiopulmonary disorders and was unable to tolerate pneumoperitoneum for long periods of time. 2. Extensive intraperitoneal adhesion. 3.The patient with intestinal perforation complicated by septic shock.

5. The authors described the level of abdominal adhesions into 0 to IV. However, there was no result on the level of adhesions between the laparoscopic versus laparotomy group. Perhaps the authors can share this result and the significance in Table 2.

Answer： We have added this result in Table 2.

6.The authors compared laparoscopic versus laparotomy, however, there was no comparison in terms of the extent of resection eg segmental ileal resection, ileo-colic resection, colonic resection or enbloc resection with fistula involving pelvic organ?

Answer： We have added this result in Table 1.

7.Discussion: Apart from balloon dilatation for strictures, authors should consider discussing the advantages and disadvantages of stricturoplasty versus intestinal resection.

Answer： Since CD affects the whole digestive system, strictures in the intestine can be treated minimally through stricturoplasty and intraoperative balloon dilatation. Although enterotomy can completely remove the strictured intestine. However, for patients with CD who have had multiple operations, there is a risk of developing short bowel syndrome with repeated resections. For stricturoplasty, conventional techniques such as HM strictureplasty and Finney strictureplasty are the commonly used methods. Although complications such as anastomotic leakage, fistula and abscess formation may occur, some reports have shown no statistical difference in CD recurrence rates between strictureplasty and enterostomy. For intraoperative balloon dilatation, an obstruction catheter is inserted through the intestinal stoma or the nose, and the size of the balloon is determined according to the degree of intestinal stenosis (Fig. 2, Video 1). Importantly, compared with traditional endoscopic balloon dilatation, this method is safe for continuous dilatation of the bowel with multiple narrow segments under direct vision.

8.It is also interesting pre-operative ultrasound scan is used to assess the degree of peritoneal adhesions to guide first port insertion. However, the results of the level of adhesions that affected the post insertion in this laparoscopic cohort were not presented or discussed.

Answer： In general, we will choose the area where the activity between the abdominal wall and viscera is greater than 30 mm to insert the first trocar.

9.The authors could consider discussing the limitation of their study and any future research direction of laparoscopic surgery in CD.

Answer： The disadvantage of this research is that it is not a randomized controlled study. Currently, many surgeons prefer laparoscopic surgery, inevitably leading to selection bias. At the moment, most researches demonstrated that laparoscopic ileocolonic resections in CD is available. But for complex or recurrent CD, there is insufficient evidence to recommend laparoscopic surgery as the preferred technique. In the future, we will continue to explore the long-term follow-up of patients with complex or recurrent CD undergoing laparoscopic resection.

We hope that the revisions in the manuscript and our accompanying responses will be sufficient to make our manuscript suitable for publication in World Journal of Gastrointestinal Surgery.

We shall look forward to hearing from you at your earliest convenience.

Yours sincerely,

Jian Wan