

Peer Review File

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Reviewer A

Although nothing new appeared, it remains a well written and comprehensive paper. Minor revision is mandatory

Title

Row 2 No abbreviations in the title

Reply: We removed the abbreviation

Changes in the text: We changed TAPP for Transabdominal preperitoneal

Abstract

Row 81-91 No abbreviations in the abstract

Reply: We removed the abbreviation

Changes in the text: We changed TAPP for laparoscopic transabdominal preperitoneal

The abstract should provide a take home message

Reply: We added message.

Changes in the text: We advise always sticking to the principles, steps, and rules. Continuous training, mentoring, online courses, video review, cadaver workshops, and following specialized social media groups are highly recommended.

Introduction

Some epidemiological data should be stated.

Reply: We added epidemiological data

Changes in the text: Inguinal hernia repair is one of the most common procedures performed around the world; around 20 million herniorrhaphies are done each year.

Row 98 "(citation)." Instead of: " . (citation) and so on"

Reply: We corrected the citations.

Changes in the text: Ex: approach (2,3). Changes were done in every citation.

Patient selection and workup

Row 119-122 There is evidence that suggests that a 4-week period of prehabilitation is useful in most patients. We follow the STRONG Guidelines, established by the American College of Surgeons, to optimize the patient's health before surgery. We are reluctant to operate patients that smoke or have a BMI > 35 in the elective setting.

Citation is mandatory here

Reply: We added the citation.

Changes in the text: There is evidence that suggests that a 4-week period of prehabilitation is useful in most patients. We follow the STRONG Guidelines, established by the American College of Surgeons, to optimize the patient's health before surgery. (8)

Row 126 USG has to be explained in the first place.

Reply: We explained the US.

Changes in the text: **Ultrasound (US)**

Row 136 According to current guidelines antibiotic administration is no longer advised for TAPP repair

Reply: We agree with you. Since we have a big percentage of patients with overweight (IMC 25-32 and patients with Type 2 diabetes we tend to use AB prophylaxis for both, open and MIS lap inguinal. Our public health institution-hospital, mandates the use of preop antibiotics when mesh or any kind of prosthesis are used. We are trying to change this prep workup for MIS lap inguinal nor for open (since there is a bit more info and support for the AB Prophylaxis)

Changes in the text: "one preoperative dose of antibiotic is used as our local hospital guidelines mandate." or if you wish we could erase this row. We will agree with both options.

Row 176 ASIS has to be explained in the first place.

Reply: ASIS is explained before; we did not change it. We added the TAP explanation.

Changes in the text: ***Transversus abdominis plane (TAP) block***

Row 215 the instead de

Reply: We did not understand what changes should be made.

Changes in the text: ***No changes.***

In general, I would advise to place the left lower side next to the bladder to avoid early relapse due to mesh dislocation.

Reply: We agree with you.

Changes in the text: ***No changes.***

Row 260-261 A liquid diet is indicated 4 hrs after surgery, acetaminophen 1 gr quad, ketorolac 10 mg tid for pain control, and preventive emesis prophylaxis are given.

Reply: We did not understand what changes should be made, since it is stated in the manuscript.

Changes in the text: ***No changes.***

Reviewer B

Dear Authors,

I appreciate your study and I think it is worth to be published. The manuscript is well done and I totally agree with your principle. However, I have several questions listed below.

① According to the Fundamental Use of Surgical Energy(FUSE), chlorhexidine plus alcohol is not recommended because it may increase the risk of operating room fire. Don't you have any experience about operating room fire?

Reply: You are correct, we do know about FUSE and you are right. We did not write this phrase in the correct manner. What we meant was: We use a traditional antiseptic cleansing agent either povidone iodine or, Chlorhexidine-alcohol (CHA) commonly composed of 2% chlorhexidine gluconate and 70% isopropyl alcohol.

Changes in the text: We use traditional antiseptic cleansing agents either povidone iodine or, Chlorhexidine-alcohol (CHA) in the surgical field.

② In the laparoscopic view, we can find the femoral hernia directly. I guess dissection between CL and iliac vein are not always necessary. Do you always dissect and check the femoral hernia in every case?

Reply: Yes. In the famous and well-known manuscript written by Jorge Daes and E. Felix called The critical view of the myopectineal orifice LETTER-PRELIMINARY REPORT/TECHNIQUE, Ann Surg 2017 Jul;266(1): e1-e2. doi: 10.1097/SLA.0000000000002104. Step 4 states that: "Dissect between CL and the iliac vein to identify the femoral orifice and rule out a femoral hernia". We do teach our residents to complete it in every case, as well as the other 9 steps. We think that this step will prevent any misidentification of small femoral hernias, and it will also make your life easier, as this step contributes to making a very big flap (downward dissection) and will also enable a very good mesh overlap with coverage of the femoral ring.

Another manuscript with very nice info about inguinal anatomy and MIS inguinal repair called, ten golden rules for a safe MIS inguinal hernia repair using a new anatomical concept as a guide Surg Endosc 2020 Apr;34(4):1458-1464. doi: 10.1007/s00464-020-07449-z. Epub 2020 Feb 19. Rule 4 states: "The external iliac vein should be visible, thus avoiding a missed femoral hernia in zone 3".

Changes in the text: No Changes

③ The size of the mesh does not influence the recurrence rate even though the hernia size seems big. Could you tell me the reason why you choose the big mesh?

Reply: We will disagree with you in this one. In almost all our cases we use a 15 x 12 (10 cm wide in patients with a height less than 1.50 mts). We do think mesh size influences recurrence especially in big direct hernias and we think that the bigger the mesh the less need for fixation. The complete myopectineal orifice should be entirely mesh-covered, in order to achieve this at least a 15 x 10 cm mesh should be used. (average 1.60-1.80 mts height male or female patient)

The reason for this conduct is:

Daes and Felix manuscript describe step 9 as "Mesh size should be at least 15 x 10 cm, although a larger piece of mesh is sometimes required to cover the MPO. Preferably, choose mesh that adapts to the contour of the space and the cord's elements. It should

not have undue memory. Place it without creases or folds. Avoid splitting the mesh. Ensure that its lateroinferior corner lies deep against the wall and does not roll up during space deflation (use glue or careful suturing if necessary). "

And the Ten Golden Rules manuscript state that: Rule 8: "A large mesh (usually at least 10 cm craniocaudal×15 cm medio-laterally) may be placed covering the MPO (Indirect, Direct and Femoral triangles) with an overlap of at least 3–4 cm "

We support this decision as stated in the following guidelines:

- Hernia. 2018 Feb;22(1):1-165. doi: 10.1007/s10029-017-1668-x. Epub 2018 Jan 12.
- Bittner R, Arreguie ME, Bisgaard T, et al. Guidelines for laparoscopic (TAPP) and endoscopic (TEP) treatment of inguinal hernia [International Endohernia Society (IEHS)]. Surg Endosc 2011;25:2773–2843. [PMC free article] [PubMed]Bittner R, Arreguie ME, Bisgaard T. et al. Guidelines for laparoscopic (TAPP) and endoscopic (TEP) treatment of inguinal hernia [International Endohernia Society (IEHS)] Surg Endosc. 2011;25:2773–2843.
- Bittner R, Montgomery MA, Arregui E, et al. Update of guidelines on laparoscopic (TAPP) and endoscopic (TEP) treatment of inguinal hernia (International Endohernia Society). Surg Endosc 2015;29:289–321. [PMC free article] [PubMed]Bittner R, Montgomery MA, Arregui E. et al. Update of guidelines on laparoscopic (TAPP) and endoscopic (TEP) treatment of inguinal hernia (International Endohernia Society) Surg Endosc. 2015;29:289–32

Changes in the text: No Changes