Review of: "Resectable Pancreatic Cancer With Peritoneal Metastases: Is Cytoreduction Combined With Hipec Effective and When?"

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Potential competing interests: No potential competing interests to declare.

Good subject, interesting for all surgeons, especially for surgeons interested in surgical oncology (like me). However, there are some points to be explained clearly;

First of all, please write HIPEC, not Hipec, in the title. The title and the abstract are the most important things in a scientific study.

In the Abstract section, why do you repeat ascites as a factor of recurrence twice? "The gender and the presence of ascites were related to recurrence ($p<0.05$). Ascites has been identified as a possible prognostic indicator of recurrence ($p=0.027$)." Why? You should delete it! Furthermore, ascites may also (more oftenly indicates inoperability!). If you think this is still possible, then persuade the readers by giving some numbers from your data! E.g., CT findings? PET score? Pre- and postop, how about PCI and CC scores? These are all missing in the abstract. In the Abstract again, ‘selected patients’—what do you mean? You have already mentioned metastatic disease—even with ascites!?—please be specific, write what you conclude exactly—do not write insignificant, nonsense, meaningless sentences as a conclusion! Let's come to the Introduction.

From the first sentence, you have many punctuation and writing faults. e.g. The peritoneum is the second most frequent site of pancreatic cancer after the liver. What site? Metastatic site? What do you mean? In the second paragraph of the Introduction, you start with CRS HIPEC, write these abbreviations out in full first. You say that CRS is performed with the intent of resecting the entire macroscopically visible tumor... are you sure? I don't think so! The purpose should be a resection of both micro- and macroscopic CA load (CC0). HIPEC strengthens treatment results by making possible unavailable surgical procedures, etc. You say, "which always remains at the peritoneal surfaces even after complete cytoreduction…" This is not true as well. Sometimes CC0 of the peritoneum is possible. How come you conclude these? Use PCI score, CC score, and abbreviations in the introduction, and re-write what I criticized previously. You again write, "'The presence of metastatic liver disease in pancreatic cancer is no longer considered unresectable disease'... how come? Upto 3-4 in number and 4-5 cm in diameter can be suitable for radiofrequency ablation (RFA)? I know the limits, but you say 'The limit of surgery in these situations is still unknown.1? Please read the Barcelona criteria or more updated criteria for liver mets, but at least write three to four generally accepted sentences in the surgical community! In the last paragraph of this section, you write, "The purpose of the present study is to update the results of a surgical team with a

limited experience," with 10 patients? I can be curious about your results, and I don't think that I'll completely rely on what you found here as a professor of surgical oncology! Insist on your preliminary results/findings/data... not the exact findings! Your own preliminary results seem to be more logical.

Methods: What is the ethics approval number? From what period did you collect patients? (Between January 2020 and June 2023?) What? Write ASA out in full first. Is the Karnofsky scale still in use? Instead of up to 100 points, using 0 to 4 points is better for clinicians, but this can stay anyhow if you use it. OK. You say again, 'The presence and the volume of ascites were recorded in detail.' There is no standard measurement way for ascites? WBC (write out in full first)... Take exclusion criteria to a different paragraph with its own title. Give the doses of chemotherapeutics in mg/kg and 60 and 90 mins separately? Is it a bit longer than expected? I know that Mit is not so effective for peritoneal mets from the colorectal experience, but if you say so, OK. We will check these in the Discussion section. Please delete the last paragraph of the Surgery section of Methods.

Results: Study periods should be taken to Methods section. Patient characteristics and complications are all listed in Table 1. Grade 1 and 2 complications? What do you mean? Do you use the ERAS protocol? Clavian Dindo scores? What? Most of your data is not reflected in tables (CA 19 levels? amylase?) In my opinion, MRCP or MR imaging and PET are both necessary to understand if the case is operable at first. Any tumor committee decisions or oncologist sign before the operation?

Discussion: First, you need to correct what I criticized above. Actually, even your number of patients is limited, the experience you gained from these patients is valuable, and I will be glad to read the revised form of this study.

What? This is not a journal? No editor? Anyhow.

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