**Editorial comments:**  
  
**General:**  
1. Please include more information about preparation (anesthesia, draping, etc.) and post-operative care and recovery. These can include citations instead of detailed protocols, and do not have to be filmed, but should be in the written protocol.

Please refer to Line.81-89

Laparoscopic low anterior resection is completed using general anesthesia10.The establishment of general anesthesia is performed routinely11, which contains preparation of GI tract decompression (including a bowel preparation and nasogastric tube placement), the neuromuscular blockade, endotracheal intubation, and fluid management12. The patient monitoring contains a noninvasive blood pressure monitor, electrocardiogram, a neuromuscular junction monitor, pulse oximetry, an airway pressure monitor capnography, and temperature monitor13.Laparoscopic low anterior resection results in less postoperative pain than conventional open surgery14. In our protocol, the surgeon follows a multimodal approach to managing the postoperative pain as reported before. 13, 15

2. We would like to see more substantial results in this section, in particular regarding outcomes and effectiveness. Have you done this procedure with multiple patients? If so, do you have statistics on outcomes, recovery rates, deaths, etc., for these patients? They can just be discussed in the text. Are there any exclusion/inclusion criteria (these could be in the protocol)? Lastly, do you have pre- and post-op imaging results (e.g., CT, MRI)? Please take a look at previous JoVE articles for examples (e.g., <https://www.jove.com/video/55590/direct-re-implantation-left-coronary-artery-into-aorta-adults-with>, <https://www.jove.com/video/55632/full-root-aortic-valve-replacement-stentless-aortic-xenografts>, [https://www.jove.com/video/56790/standardized-technique-aortic-valve-re-implantation-for-valve-sparing](https://www.jove.com/video/55632/full-root-aortic-valve-replacement-stentless-aortic-xenografts)).

Thanks for the suggestion and the examples. Please kindly find the revised version below.

**REPRESENTATIVE RESULTS:**

**Intraoperative data**

In this protocol, the surgeon selected the medial side approach. The anterior wall of the rectum was lifted up to extend the right-side peritoneum of the rectum. The surgeon used an ultrasonic shear to dissect the peritoneum at promontory level along the concave of peritoneum and toward the peritoneal reflection (Figure 1A). In this protocol, the surgeon used sharp and blunt dissection to incise the peritoneum, and identify the correct plane without any injury of the ureter (Figure 1B). When the surgeon completely skeletonized the IMA, the hypogastric nerves were also identified and protected carefully (Figure 1C). Figure 1D shows the preservation of the left colic artery (LCA) in laparoscopic low anterior resection; the superior rectal artery (SRA) was ligated. The left colic artery (LCA) and superior rectal artery (SRA) are divided.

**Early postoperative data**

The observed rate of R1 resection for the entire patient cohort was 1.4%. Concerning the post-operative complications, anastomotic leakage happened in 7% patients. Specifically, in the group with preservation of the left colic artery (combined with 253# lymph node dissection), the anastomotic leakage rate was 5%, in the corresponding non-preservation group, the leakage rate was 7%. Concerning the quality of TME, among the 104 resections, 95% were mesorectal resection, 5% were intramesorectal resection.

In our previous study, the laparoscopic TME has been evaluated for rectal cancer patients with elevated operative risk, which was defined as Cr-POSSUM > 5% combined with associated risk factors. The 5-year overall survival rate of these patients was between 65% to 75%16.

3. Please proofread and make sure the references have a consistent formatting (e.g., either all journals abbreviated or all not abbreviated).

The author has proofread the manuscript to try to have a consistent formatting.