Dear Editors and Reviews,

Thank you for your letter and valuable comments.

We have carefully revised the manuscript according to editorial comments and the instructions for authors. Major modification has been made. Specifically, when evaluating the outcomes of the procedure, only patients undergoing laparoscopy were included in the revised article. Patients with cervical or intraligamentous fibroids were also excluded. Thus, the number of cases is lessened.

Besides, Yuting Xiang should be added as a co-author. This decision is approved by all the other authors of this article, as she contributed a lot to the revision of this manuscript.

The responds to reviewers’ comments are as follows:

Review #1:

Major Concerns:  
Is this technique practical in all types of cases, specially in degenerated myomas?  
Response: In the revised manuscript, we illustrated the inclusion and exclusion criteria of patients. Patients with degenerated fibroids were excluded in the current study. But it remains to be determined whether IRCP should be applied to degenerated fibroids. Red degeneration, cystic degeneration and fatty degeneration all lead to softer texture of the tumor and impaired contraction of the myometrium. In this case, it is not easy to detach the fibroid from its pseudo-capsule by IRCP.

The use of monopolar for making semiring incisions on myomas will produce a lot of smoke which can interfere with visibility of surgical field.  
Response: The ports were established by standard techniques: a 10 mm umbilical port, as well as a 5 mm and a 10 mm ancillary ports in the lower abdomen. The 5 mm port was connected with a plastic tube for vacuum drainage, which can suck the smoke during surgery.

Minor Concerns:  
How do you explain that the total time of the surgery is less, as the technique invloves time for multiple semiring incisions in a smoke filled operative field?  
Response: It seems to take more time for fibroid detachment. But the residual cavity is shallower and easier to suture, so it takes less time for suturing. Thus, the total time of the surgery can be less.

The weakness of the study is not highlighted.

Response: we acknowledge that there exist some limitations of IRCP:

1.IRCP is not suitable for pedunculated subserous fibroids or submucous ones.

2. It remains to be determined whether IRCP should be applied to degenerated fibroids. Red degeneration, cystic degeneration and fatty degeneration all lead to softer texture of the tumor and impaired contraction of the myometrium. In this case, it is not easy to detach the fibroid from its pseudo-capsule by IRCP.

3.As a moderated morcellation procedure, IRCP may result in potential dissemination if malignancy exists. However, with careful pre-operation evaluation for risk of malignancy and strictly following the procedures to perform inside of the pseudo-capsule, this risk can be minimized. In addition, it is difficult to operate when the major part of the fibroid is still inside the pseudo-capsule and it requires some patience. But when most part the fibroid is outside the incision, it slips out spontaneously.

Review #2:

Major Concerns:  
The original intracapsular laparoscopic myomectomy technique should be reported in the introduction and in the references. I probably did not understand the reasons for the modification of the technique, because the authors perform multiple rotary-cuts on the fibroid with a monopolar electrical knife. What advantage do they have compared to the traditional method.  
Response: Thanks for the comments. We have carefully reviewed the articles on laparoscopic myomectomy.

The similarities between IRCP and the traditional method include: 1) intracapsular procedure. 2) Incise on the most protruding site of the fibroid and open the pseudo-capsule by longitudinally. 3)hold the fibroid longitudinally to expose the boundary between the fibroid and peuso-capsule.

The difference is as follows:

|  |  |  |
| --- | --- | --- |
|  | IRCP | traditional LM |
| ischemic solution | 6 U Pituitrin and 20 U Oxytocin diluted in 10 mL saline | not used |
| length of incision | no more than half of the fibroid diameter | not described |
| procedure | Perform multiple rotary cuts on the fibroid in depths of 5-10 mm, shrinking the diameter of the tumor. Then the fibroid will be squeezed out by contraction of the pseudo-capsule and myometrium. | The fibroid is removed after detachment from the psudo-capsule. |
| residual cavity | small and shallow | not described |
| suture | a single-layed suture | a single layer for subserous fibroids and double layers for intramural ones |

The advantages of IRCP compared to the traditional method:

1)smaller incision; 2)shallower residual cavity; 3)less bleeding; 4)easier to suture

The smaller incision caused less damage to the myometrium, which can protect the neurovascular structure of the pseudo-capsule as much as possible. It is beneficial for postoperative uterine healing and fertility preservation. Patients desiring pregnancy can conceiver six months after surgery.

The infra-ligament myomas are VERY DANGEROUS, as in these structures the uterine vessels, the ureters and the large iliac vessels run.

Response: This procedure is performed inside the pseudo-capsule and it is especially suitable for cervical and intra-ligamentous fibroids. Although fibroids of unusual locations are not illustrated in the current article, we have achieved successful experience in managing intra-ligamentous fibroids with IRCP. As the surgery is performed inside the pseudo-capsule, it effectively avoids injury of uterine blood vessels and ureters. Usually, the pseudo-capsule of intra-ligamentous fibroids is looser, it is easier and safer to perform IRCP.

Why the authors try to reduce the fibroid from the spheroid fibroid to lobulated shape? What is the real advantage?At the most they can fragment myoma, with all the problems that derive from it.  
Response: We perform multiple rotary cuts on the fibroid in depths of 5-10 mm, shrinking the diameter of the tumor, instead of cutting the tumor into pieces. Therefore, the risk of dissemination is not increased.

But how does the pseudocapsule to squeeze the fibroid out of the myometrium ???

Response: The fibroid is pulled out by the instrument and squeezed out by the contraction of surrounding myometrium.

Minor Concerns:  
How many WATTS do the authors select the electrosurgical unit to cut the pseudocapsule with scissors?

Response: 30 watts.

Thank you again for your effort.

Sincerely,

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