RDP, in comparison to traditional DP techniques for treating disorders of the pancreas body and tail, appears to have clinical and oncological advantages. However, it may involve a lengthier operation and learning curve according to a meta-analysis, in contrast to the shorter learning curve mentioned by Alvarez et al.[5] It is noteworthy that the study's stated non-significant difference in the length of the two operations is, in fact, significant in the multicenter analysis conducted by Lof et al. with a much larger sample size that found a similar difference in procedure durations.[6]

In conclusion, encouraging further research in the field of minimally invasive procedures, exploring novel surgical procedures, and providing long-term follow-up while addressing the limitations mentioned in the study can pave the way for improved outcomes, enhancing patient care.

Statement and declaration

The authors have no relevant financial or non-financial interests to disclose.

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Laparoscopic and robotic distal pancreatectomy: the choice and the future

First of all, the authors would like to thank you for your comments and the analysis of the article.

As it highlights, the implementation or incorporation of the robotic platform must follow the surgical principles and must demonstrate its effectiveness, efficiency, and safety, so we believe and so we raise it when analyzing our results.[1,2]

In response to the questions raised. We have not analyzed the degree of induced diabetes after distal pancreatectomy. Our study assesses short-term outcomes. We consider your comment and keep it in mind for future analysis.

Regarding the perception and satisfaction of the patients, as well as the functional recovery. This analysis is a departure from the main objectives of the study, and would in itself deserve to be presented in a single article. Nevertheless, we consider it elementary and have already incorporated it into the set of variables to be analyzed in daily clinical practice.

We have carefully reviewed the articles referenced in your letter. We have not found a clear justification in both studies as they have not used a learning curve analysis methodology and both have some biases in this respect.

We believe, and this has been our experience, that the robotic platform shortens the learning curves. As Müller et al. reported, the analysis of learning curves in literature is arbitrary in some cases.[3]

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In the last years, new literature has become available, and robotic pancreatic surgery had a significant expansion. Recently, the internationally validated European guidelines on minimally Invasive Pancreatic Surgery proclaimed that the learning curves for robotic distal pancreatectomy are slightly shorter compared with a laparoscopic approach. Apart from, minimum center volumes and indications for minimally invasive surgery were the most debated topics.[4]

Again, we would like to thank you for your suggestions.

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Comment on "Sheathed goring: An unusual bull-horn injury"

Comentario a "Cornada envainada: una lesión por asta de toro infrecuente"

Dear Editor,

We have reviewed with great interest the manuscript recently published in the journal, *Cirugía Española*, by Benítez Riesco et al.[1] We would like to congratulate the authors on their work and their contribution to the visibility of a rare but sometimes devastating injury in terms of morbidity and mortality.[2]

Sheathed goring, also known as "goring of the healthy" or "internal goring", is defined as a subtype of penetrating bull-horn trauma, where, despite the skin remaining intact, there is injury to the deeper structures and tissues, which may be associated with eventrations or vascular and visceral injuries of greater severity. In reality, it is a contained evisceration. This peculiarity of bull-horn trauma is due to the characteristics of the kinematics of the bull's charge and the high elastic capacity of human skin, maintaining its integrity uninterrupted (this can sometimes be associated with slight superficial alterations: ecchymosis or haematomas).[3,4]

Few authors in the literature describe this type of trauma, and almost all are descriptions of isolated clinical cases.[2,4–7] At the Surgery Dept. of the Hospital General Universitario in Castellón, we published our experience after undertaking the largest review of bull-horn trauma injuries recorded to date.[8]

In our series of 572 patients, we report an incidence of sheathed goring of less than 1% (0.7%). The 4 affected patients (male, with a mean age of 35 years) had sustained blunt bull-horn trauma at abdominal level with complete skin integrity. All were seen in the emergency department as polytrauma patients, and after primary ATLS (Advanced Trauma Life Support) assessment, a computerised axial tomography (CAT) scan was run and emergency surgery undertaken. In 75% of patients, associated visceral injuries (renal, intestinal and mesenteric injury) were observed. After specific surgical treatment for each type of lesion, primary repair of the abdominal wall was performed, in half of the cases with the placement of a prosthetic mesh, with no differences being observed between the two in terms of subsequent recurrence or infections (0% in both techniques). The mean hospital stay was 8 days, no patient stayed in the intensive care unit, and the mortality rate was zero.