**Response to reviewers**

Reviewer #1:

* “I think it is an error for you to focus in both your abstract and conclusion on the small (and as you appropriately point out, non CLINICALLY significant) difference in organ space SSI. Rather, I would encourage you to shift the tone of the paper to be more about the fact that there is no real clinical difference.” **Agreed**. **This is exactly what we were ultimately trying to say and we have changed the abstract and conclusion to reflect this**.
* “it seems as though at some point in the paper you are trying to ask the question of antibiotics (should we or should we not be giving them for routine lap chole)? I think this is actually a great question but in the setting of your paper, it comes across a bit jarring as you don't really set the reader up for it appropriately. For example, in the abstract conclusion, you say there is a difference in infection and antibiotics are unclear, but this is the first time you have brought up antibiotics. If you want this to be a question in the paper you need to 1) bring it up earlier (like in the introduction), and 2) either add info on antibiotic use in your cohort or explain why you don't have it. “ **Agreed – unfortunately the info on antibiotic use in our cohort is not available via NSQIP. We have removed mention of antibiotics from the abstract and conclusion but discuss it briefly in the discussion. We additionally mention the limitation of our data.**
* “I worry that your wound classification is not the most accurate way to determine bile spillage. Understanding the limitations of the NSQIP dataset, I think it was reasonable for you to consider class I/II "routine" and class III "bile spillage" (with the exclusion of concomitant procedures as you describe). However, a class 4 case, meaning infected, would hypothetically indicate that the surgeon found acute cholecystitis when they entered. You otherwise excluded acute cholecystitis so why not exclude class 4 cases?” **We specifically exclude acute cholecystitis by ICD code. By doing this, we then accept class 4 cases to be included to increase the number of bile spillage patients in the study. We decided this was a reasonable trade off and assumption because while some of these class 4 cases may actually be acute cholecystitis with an incorrect ICD code or inadvertent entry into small or large bowel without documentation of a second procedure, this should actually artificially INCREASE the SSI rate in the bile spillage group, thus making the groups appear MORE different, rather than more similar. We believe this to be the more conservative assumption because we would rather find a difference in SSI rates where none exists rather than find no difference where one does exist (accepting a higher false positive rate), because this would lead to a more conservative conclusion (more in line with the a priori assumption that bile spillage is associated with increased SSI rates as demonstrated by prior studies that include acute cholecystitis in their cohort). The fact that we found no difference in rates despite potentially including a few cases with acute cholecystitis strengthens the finding of no significant difference.**
* Why exclude based on operative time? Assuming <15 minutes would be an aborted procedure but longer and more difficult cases may have been interesting to include. **We were simply trying to exclude prolonged case duration, which is a known risk factor for SSI, for the same reasons we excluded cases with documented acute cholecystitis by ICD code and cases with additional procedures. While this decreases the generalizability of the study, it strengthens the conclusion of no significant difference when applied to routine, elective, “simple” gallbladders that take less than four hours (which is the vast majority of LCs). Additionally, a longer operative time implies a more “difficult” gallbladder which is likely correlated with higher rates of bile spillage. This could have therefore *confounded* any finding of higher SSI rates in the bile spillage group. Although it might have appeared that higher SSI rates were due to bile spillage, they in fact may have been due to longer operative times in that group (since prolonged case duration is a well-documented SSI risk factor).**
* How accurate do you think surgeons are in wound class documentation? Operative reports might have been a better way to get at this information, though understandably would have been MUCH more challenging to access. DO you think surgeons OVER document wound class to protect themselves in case an SSI happens? **Agreed, operative reports would have been better, but this is obviously impossible to get with NSQIP. Yes, we think it’s a fair assumption that surgeons over document wound class to some degree. We have discussed this in our limitations as advised.**

**We have reviewed, accepted, and applied all content and grammar suggestions.**

Reviewer #2

* These a very interesting study, but it still a retrospective one and there was no clear mention of bile spillage in the NSQIP registry. The study would be stronger if it was mentioned clearly with a specific classification. **Yes, unfortunately we are limited by the data provided by NSQIP.**
* Patients with acute cholecystitis could be included in this study and it and it would have been a very interesting sub-group to analyze. **We felt as though prior literature has adequately addressed the question of bile spillage in acute cholecystitis. While our paper is not widely generalizable to all pathologies for which a patient may be undergoing laparoscopic cholecystectomy, we designed this study to be specifically applicable to the benign, routine, elective gallbladder.**

**We have reviewed, accepted, and addressed all minor remarks.**