

## Peer Review File

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### Reviewer A

This is an interesting study by Hao et al. The authors demonstrate that in patients in whom the Foley catheter is removed at seven days after surgery do better in regards with recovery of continence as well as OAB symptoms. The authors are congratulated for asking a question that is important for patient satisfaction.

The main critique however of the study is that the three groups that the author study are non-randomized. The author state that the decision to remove Foley at 7 days, 10 days, or at 14 days was made by the patient. It is unclear why the patient made that decision? It must have something to do with the way the patient was counseled, I assume. Further, the details regarding intraoperative process such as may be a bigger bladder neck, maybe an anastomotic leak (even a minor one), radiation to the pelvis, or some other concerns that the surgeon had that may have led to longer need for the indwelling Foley catheter are lacking, and these factors would serve as biasing factors in the delayed continence.

**Reply:** We would like to thank you for your careful reading, helpful comments, and constructive suggestions. As you mentioned, when patients were scheduled for urinary catheter removal, they were evaluated by a specialized nurse. Cystography was routinely performed to confirm that there was no anastomotic leak. If the cystogram shows evidence of extravasation, the catheter is retained for at least 14 days. And in some patients requiring extensive bladder neck reconstruction, or with great tension in the urethral anastomosis, the catheter was also recommended to retain for more than 14 days. One patient had previous pelvis radiation history, which might lead to severe scarring around the urethra, and he had an unhealthy appearance of the surrounding tissue during the operation. He had kept the catheter for 3 weeks. If none of the above occurred, we would inform the patient that the catheter can be removed on 7/10/14 days after surgery, and the patient would make an appointment for the removal of the catheter through the online outpatient appointment system. Patients could choose an appointment time that is convenient for them. At the time of removal, our nurse specialist would record the time of removal. Some patients might have concerns about early removal of the catheter, or might have mobility problems and wanted to keep the catheter for a longer period of time, and these patients often chose 14 days or longer when making an appointment for their catheter removal.

**Changes in the text:** We have modified our text as advised (see Page 6, line 19-22, Page 7, line 1-8)

Furthermore, when evaluating early continence after radical prostatectomy, details regarding nerve sparing, bladder neck sparing, bladder neck reconstruction are important. In a recent search study by Sood et al (<https://pubmed.ncbi.nlm.nih.gov/35579026/>) they have shown that bladder neck preservation is the most important and probably the only factor that is responsible

for early continence. Thus the authors should. provide details on these factors and discuss their findings in light of these recent studies.

**Reply:** As you mentioned, there are many factors that influence early continence recovery based on recent studies. Such as nerve sparing, bladder neck sparing, and bladder neck reconstruction. In our study, for low-risk patients, a neurovascular bundle (NVB) sparing procedure is performed. However, due to the predominance of middle-high risk patients in the enrolled group, the percentage of nerve-sparing was only 15.7% as described in the manuscript. And when we explored the factors influencing the recovery of continence, a univariate analysis of possibly relevant factors was performed, and the results showed that nerve sparing did not influence the continence recovery in this study (OR 0.877, 95% CI 0.674-1.141). With regard to bladder neck preservation and bladder neck reconstruction, we did not intentionally perform bladder neck preservation during the procedure and therefore it was not included in the analysis. However, according to Francesco et al. (<https://pubmed.ncbi.nlm.nih.gov/26297603>), performing total periurethral reconstruction improves early urinary control outcomes, and therefore, in our study, a total periurethral reconstruction was routinely performed in all patients.

**Changes in the text:** We have modified our text as advised (see Page 13, line 3-17)

**Red color was used to show the changes of the manuscript.**

#### **Reviewer B**

Although it is a retrospective study, I think that meaningful new results have been extracted from the experience of many cases.

I appreciate the meaningful analysis from the great experience of robotic prostatectomy.

**Reply:** We thank the reviewer for reading our paper carefully and giving the above positive comments.