

Peer Review File

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Comment 1 (from reviewer A): I think that this is a well-written and timely Editorial. One aspect of ATLAS that I found particularly interesting were the progression events between the two arms (Table 2), plus a lot of missing data for progression events. This is a weakness of the study, and possibly the real reason that the trial stopped early.... I think that the Editorial should capture these data - both presented and missing.

Reply 1: We agree, this is a notable limitation of the study and should be included in the manuscript. See our addition to the text below:

Change in text: “Lastly, there was a large number of patients with missing DFS data in both groups, making it difficult to interpret the results of the study. In particular, in the control TURBT arm, of the 85 patients who did not have a DFS event, only 49 were disease free at the end of the study with the remaining 36 patients either having no post-TURBT assessment or withdrew from or violated the study. (page 4, line 7-12)

Comment 2 (from reviewer B): This editorial commentary is relevant in the current context of new intravesical treatments, especially for IR-NMIBC with the aim of reducing side effects and maintaining QOL of our patients. It impartially highlights the strengths and limitations of this phase III study.

Reply 2: Thank you for the feedback and for supporting our manuscript. No edits to the manuscript were made as a result of these comments.

Comment 3 (from reviewer C): The main drawback of the Atlas study may be the lack of adjuvant therapy in monoTURBT arm. This could have affected the results of the study, even though the study had been stopped from recruiting by the sponsor and had been stopped early, prior to half of the accrual goal being reached.

Reply 3: We agree that this is a critical point in terms of weaknesses of the study. We further expounded on this point, which can be seen in the change in text below:

Change in text: Both a single dose of intravesical chemotherapy as well as repeated

instillations have both been shown to provide an absolute risk reduction of recurrence – 27% and 13-14%, respectively.^{7,8} For intermediate risk patients, both of these treatment modalities should be offered to patients and may explain some of the difference in DFS as one group received intravesical therapy at the time of surgery and the other did not (page 4, line 1-5).