

## Peer Review File

**Article information:** <http://dx.doi.org/10.21037/tau-20-1075>.

### Reviewer A

This study was reported the utility of RARC followed by intracorporeal ileal neobladder. This paper has many problems to accept the Journal of TAU. The reviewer would like to suggest some critiques as follows.

#### Major revision

1. First of all, this paper was vital weakness. Because the enrolled patients were very small and the follow-up period was very short.

**Authors' response:** Thank you for your professional advice. We are strongly agreed with your advice. The Da Vinci Surgical System was first introduced to our institution in June 2016. Honestly, we were cautious of the intracorporeal ileal neobladder technique in consideration of its complexity and our limited experience. Besides, patients' willingness played an important role in the choice of surgical procedure. The vast majority of them chose urinary diversion on abdominal wall. In this paper, we would like to share our initial experience to do some favor in assessment of this technique. We have made an explanation for this limitation (see Page 14, line 13–16).

**Changes in the text:** *Considering the complexity and challenge of the intracorporeal ileal neobladder technique, intense caution was exercised during the initial stage. The vast majority of patients chose traditional urinary diversion on abdominal wall rather than this technique.*

2. Median follow-up was a short time compared with other reports. Therefore, the authors should not describe 12-months RFS and OS.

**Authors' response:** Thank you for your professional advice. After discussion, we reached an agreement that 12-months RFS and OS in our study may not be convincing. We have modified our text as advised.

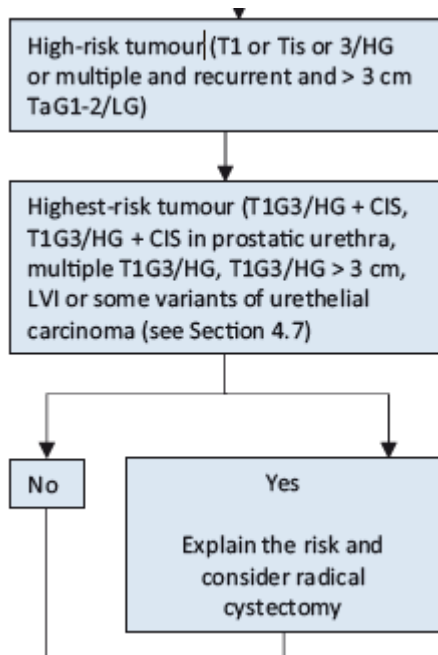
**Changes in the text:** *The median follow-up time was 13.1 months (range: 5.4–32.0), and two patients died due to metastasis after 17 and 22 months (Table 3).* (see Page 10, line 13–15)

*A longer follow up is required for improved evaluation of the prognosis.* (see Page 14, line 16,17)

3. Why did the authors underwent RARC in patients who diagnosed NMIBC?

**Authors' response:** Thank you for your professional advice. According the EAU

Guidelines on NMIBC, radical cystectomy is considered an initiative treatment option when the tumor is high-risk NMIBC (figure below is captured from EAU Guidelines 2018 edition on NMIBC Flowchart 7.1: Treatment strategy in primary or recurrent tumour(s) without previous BCG). NMIBC in this study were all high-risk tumors and consistent with surgical indications. We have mentioned this before in the text (see Page 5, line 6–8).



4. The authors reported that two patients died of bladder cancer. The authors should describe what did these patients diagnosed pT stage, developed metastatic sites, and received treatment after metastasis.

**Authors' response:** Thank you for your professional advice. We have modified our text as advised (see Page 10, line 15–22).

**Changes in the text:** One patient was diagnosed with pT3b stage and received gemcitabine and cisplatin chemotherapy. Fourteen months after the surgery, this patient exhibited abdominal metastasis, as shown in computed tomography, and gave up treatment and died at the 17th month. Another patient was diagnosed with pT3a stage. Thirteen months after the surgery, this patient exhibited pelvic and sacrum metastasis, and gemcitabine and cisplatin chemotherapy was adopted. Programmed death-1 immunotherapy and docetaxel chemotherapy were used later. Extensive abdominal metastasis was confirmed by laparotomy at the 22nd month.

**Reviewer B**

The language requires major revision, as the manuscript is littered with grammatical errors.

**Authors' response:** Thank you for your professional advice. This manuscript has been checked by a professional language checker. The certificate has been offered to the

editor.

With regards to the scientific portion of the manuscript, these are my comments:

Methods:

1) "Six patients accepted the standard pelvic lymph node dissection (PLND)."

PLND is a standard part of surgery for any radical cystectomy for bladder cancer. It is useful for staging, and may confer an oncological benefit. The authors need to explain why only half of the patients underwent PLND.

**Authors' response:** Thank you for your professional advice. We have modified our text in limitation portion (see Page 14, line 19–22).

**Changes in the text:** PLND was not performed in some patients diagnosed with non-advanced cancer. Though no evidence of lymph node invasion was found through preoperative imaging examination, intraoperative vision and the follow up, surgery without PLND may cause some patients to lose potential oncological benefit.

2) "All patients were required to maintain a fluid diet two days before surgery and to perform a fasting and a cleaning clyster the day before surgery. "

What is a cleaning clyster?

Why are patients fasted the day before surgery? The authors should be familiar with the Enhanced Recovery After Surgery (ERAS) protocol which helps to improve outcomes after cystectomy. Prolonged fasting is detrimental to patients undergoing cystectomy (or any major surgery)

**Authors' response:** Thank you for your professional advice. Fasting was for bowel preparation and parenteral nutrition was given. ERAS is a good protocol and we are very glad to conduct it in our following surgery. We have supplemented this in limitation portion.

A cleaning clyster means enema with 0.1-0.2% soapy water. And the enema was performed twice actually. We have modified this fault in our text.

**Changes in the text:** Besides, an enhanced recovery after surgery could be conducted to improve the outcomes. (see Page 14, line 17,18)

all patients were required to maintain a fluid diet 2 days before surgery. Fasting was performed for bowel preparation 1 day before surgery, and parenteral nutrition was provided. A cleansing enema was performed 1 day before surgery and on the day of surgery. (see Page 5, line 8–12)

3) The authors can state their postop management as well. For example:

a) length of time that the ureteric stents are kept

b) whether a postop cystogram was done to check for leak before removal of the catheter

**Authors' response:** Thank you for your professional advice. We have modified our text as advised (see Page 9, line 3–8).

**Changes in the text:**

*Postoperative management*

The neobladder was irrigated every 8 hours from day 1 after the operation. The drain was removed when fluid was < 150 mL/day and the creatinine of the fluid was measured to exclude urinary leakage. The catheter was removed routinely between 2 and 3 weeks. The ureteric stents were taken routinely at 4 weeks. Postponing was adopted if the patient had severe urinary tract infection.

Surgical technique

4) The authors spent a long time describing the location of their ports, but did not mention where the 4th arm of the robot was placed.

**Authors' response:** Thank you for your professional advice. We adopted A five-port transperitoneal approach in this study—one camera port, two robotic ports and two assistant ports. No more robotic arms were involved.

5) Overall the surgical technique portion can be summarised and significantly shortened. For example, for the description of the PLND portion, just stating the boundaries of the dissection will be sufficient.

**Authors' response:** Thank you for your professional advice. We were meant to present detailed surgical procedures since our institution had not reported intracorporeal neobladder before. We have modified our text as advised.

**Changes in the text:** ~~The dissections close to nerve and vessels were performed with the maximum help of cold scissors or bipolar forceps avoiding potential ultrasonic heat damage to them. After the PLND, the left ureter held by the marking suture was moved to the right side under the sigmoid.~~ (see Page 7, line 1–4)

~~Great cares were taken into avoiding damage to the hemal arch of the ileum segment when the ileum segment and its surrounding mesentery were dissociated.~~ The small bowel continuity was restored by performing a side-to-side stapled anastomosis (Fig. 3). ~~One 1 cm incision was respectively performed 2–3 cm distant to proximal and distal ends of the bowel by monopolar scissors.~~ (see Page 7, line 13–17)

Results

6) "One early case underwent a uroschisis with urinary tract infection, further

developing into sepsis. "

What is meant by "underwent a uroschisis"?

**Authors' response:** Thank you for your professional advice. "uroschesis" means acute urinary retention. We have modified our text as advised (see Page 10, line 25& Page 11, line 1) and Table 4 was also modified in red.

**Changes in the text:** One early case developed acute urinary retention with urinary tract infection, further developing into sepsis.

Discussion

7) "Our perioperative outcomes were almost comparable to previous literatures except for a longer hospital stay (9,14), which could be expected since our experience of RARC with intracorporeal neobladder was at an early stage and sufficient caution seemed necessary. "

The length of stay may be shortened by incorporating ERAS protocols as well. The median time to bowel function recovery was 5.5 days. Why did patients stay another 9 days after this? (median hospital stay of 14.5 days)

**Authors' response:** Thank you for your professional advice. We have learned the benefits of ERAS and consider to carry it out on (1-4). We have supplemented this in limitation portion. The reasons that patients stay another 9 days after bowel function recovery are listed below: First, medical environment in China does not allow most efficient bed turnover rate. A long postoperative hospital stay could be observed in most hospitals, even if the ERAS protocols was been adopted (5). Second, postoperative complications did not allow some patients' discharge. Third, sufficient caution seemed necessary due to our limited experience of RARC with intracorporeal neobladder. We have modified our text for better illustration.

**Changes in the text:** The perioperative outcomes in the present study were almost comparable to those in previous literatures except for longer hospital stay (9,14), which could be expected give that the authors' experience of RARC with intracorporeal neobladder was at an early stage and sufficient caution seemed necessary. This finding could be improved with increasing cases of intracorporeal neobladder. (see Page 12, line 13–18)

Besides, an enhanced recovery after surgery could be conducted to improve the outcomes. (see Page 14, line 17,18)

1. Nabhani J, Ahmadi H, Schuckman AK, et al. Cost Analysis of the Enhanced Recovery After Surgery Protocol in Patients Undergoing Radical Cystectomy for Bladder Cancer. Eur Urol Focus 2016;2:92-6.
2. Daneshmand S, Ahmadi H, Schuckman AK, et al. Enhanced recovery protocol after radical cystectomy for bladder cancer. J Urol 2014;192:50-5.

3. Tan WS, Tan MY, Lamb BW, et al. Intracorporeal robot-assisted radical cystectomy, together with an enhanced recovery programme, improves postoperative outcomes by aggregating marginal gains. *BJU Int* 2018;121:632-9.
4. Koupparis A, Villeda-Sandoval C, Weale N, et al. Robot-assisted radical cystectomy with intracorporeal urinary diversion: impact on an established enhanced recovery protocol. *BJU Int* 2015;116:924-31.
5. Lin T, Li K, Liu H, et al. Enhanced recovery after surgery for radical cystectomy with ileal urinary diversion: a multi-institutional, randomized, controlled trial from the Chinese bladder cancer consortium. *World J Urol* 2018;36:41-50.