Peer Review File

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Reviewer A: This study was reported the utility of surgical technique with intracorporeal ileal conduit after laparoscopic radical cystectomy. The reviewer would like to suggest some critiques as follows.

Major revision

Comment 1: First, what is the primary endpoint in this study? Surgical technique? Oncological outcomes?

Reply 1: As a modified technique, it is important to test its safety and feasibility. So 90-day complications was the primary endpoint.

Changes in the text: We have modified our text as advised (see Page 2, line 29-31)

Comment 2: In Abstract section, what is BMI on line 34? The authors should spell out.

Reply 2: We have modified our text as advised (see Table 1)

Comment 3: On line 38, “4(8.3%) patients” is wrong. “4 patients (8.3%)” is correct.

Reply 3: We have modified our text as advised (see Page 2, line 33-34)

Comment 4: On line 42-43, What are mild, moderate, or severe hydronephrosis? What is compromised renal function? What are mild, moderate, or severe compromised renal function?

Reply 4: We have modified our text as advised (see Page 5, line 93-97)

Comment 5: On line, 154, the authors reported that median EBL was 200mL. However, 6 patients (12.5%) required blood transfusion. The reviewer think that the rate of patients who underwent blood transfusion is high. The authors should described this reason.

Reply 5: These 6 patients belonged to the first half of the whole cohort. The mean estimated blood loss of them was 433.3 ml. The learning curve might exist and influence the transfusion rate.

Changes in the text: We have modified our text as advised (see Page 9, line 182-183; page 12, line 251-252)

Comment 6: On line 160, “transitional cell carcinoma” is wrong. “urothelial carcinoma” is correct.
Reply 6: We have modified our text as advised (see Table 3)

Reviewer B: The authors report the experience and treatment outcome of 48 cases of ICIC. The operation time is short and the complication rate is reasonable, and the result seems to be good. This paper will be improved by examining the following points.

Comment 1: Most papers on ICUD appear to be performed by using the robot. Laparoscopic ICUD appears to be more difficult, but what do the authors think about it? Please consider it in the discussion part.
Reply 1: We have modified our text as advised (see Page 14, line 284-289)

Comment 2: The description of ileal conduit ureteral anastomosis is a little difficult to understand. There are pictures during the operation, but if possible, please add a schema.
Reply 2: We have added one of our previous studies. (see Page 7, line 139)

Comment 3: The strictures of uretero-ileal anastomosis are thought to become more common over time. In this respect, the percentage of hydronephrosis seems to be a little high at less than 20% in half a year after surgery in this study. What do you think about it? Please discuss this point.
Reply 3: We have added information of preoperative results of hydronephrosis and compromised renal function, and made a comparison between pre- and postoperative data.
Changes in the text: We have modified our text as advised (see Table 4; Page 11, line 211-212)

Reviewer C: This study demonstrated the utility of modified ICUD in LRC with single

center 48 cases experience. The author well described operative procedure and perioperative complications.
However, I suppose to notice three major shortcomings to improve the contents.

Comment 1: First, If the author wanted to demonstrate the utility of this modified ICIC method, I strongly recommend the author should compare with ECUD cohort in your hospital. Otherwise, “modified ICIC could reduce surgical difficulty and achieve a relatively short operative time, and resulted in acceptable perioperative results and reliable oncologic outcomes” is overestimated as a conclusion. And the utility or difference of modified ICIC procedure itself compared with previous report was still vague. The author should emphases this point in Material and Method.
Reply 1: We have recomposed our conclusion and made revisions in Material and Method.
Changes in the text: We have modified our text as advised (see Page 3, line 45-46; page 7, line 143-146; page 15, line 311-312)

Comment 2: Second, there are many studies about ECUD vs. ICUD in RALC and as the author mentioned, there are some studies about ICIC vs. ECIC. So, this study is not sufficient with novelty. At least the author should compare with ECUD cohort in your hospital.
Reply 2: The main object of this article was to introduce our modified technique of intracorporeal ileal conduit together with ERAS protocols. So we explained the surgical technique and ERAS protocols in detail, and compared the results of ERAS and non-ERAS group. Due to the limitation of word count, there would be too much information if we added ICUD data in this article. We would perform a comprehensive analysis and comparison between EUCD and ICUD in the future research.

Comment 3: Third, this study described the feasibility of ERAS protocol for LRC and ICIC. However, the author wanted to mention the utility of both ERAS and ICIC method itself. Through the whole, the arguing point is vague. As for bowel function recovery, this study protocol did not demonstrate which is effective to this. I recommend that analysis of “ICIC without ERAS vs. ECIC without ERAS“ or “ICIC with

ERAS vs. ICIC without ERAS" should be preform.

Reply 3: We have already added information about ERAS and non-ERAS patients.

Changes in the text: We have modified our text as advised (see Page 2, line 27-28, 37-40; page 9, line 183-186; page 10, line 190-197; page 13, line 257-274)

And some minor points are pointed out as follows,

Comment 4: The author used low/high grade complications as terms. It is not standard method of notation.

The author should use minor (Clavien 1-2) and major (Clavien 3-5) complications like line 218-219.

Reply 4: We have modified our text as advised (see Page 12-13, line 233-254)

Comment 5: Mean follow up periods was 25.4 months, what is the reason the author used 2-year OS, not more longer OS, CSS?

Reply 5: Though the mean follow-up was 25.4 months, the median was 15 (7-49) months. So we think it would be more appropriate to calculate 2-year results.

Comment 6: Despite median EBL was 200ml, why was the rate of intraoperative blood transfusion so high? Did all patients undergo neoadjuvant chemotherapy (but only 25% received chemotherapy)?

Reply 6: We have modified our text as advised (see Page 9, line 182-183; page 12, line 251-252; Table 1)

Comment 7: In line 179, The author mentioned 4 patients (11.1%) had moderate or severe compromised renal function. Were these patients' preoperative renal function normal? Were these changes caused by urinary diversion/hydronephrosis? I think this rate was relatively high.

Reply 7: We have added information of preoperative hydronephrosis and compromised renal function, and made a comparison between pre- and postoperative data.

Changes in the text: We have modified our text as advised (see page 11, line 211-212; Table 4)

Comment 8: In line 249, “LRC with ICIC was finished through a minimally invasive method, which could brought smaller wound and reduced pain.” Is that true? Where do you remove the specimen? I don't believe ICIC could reduce the size of wound and its pain.

Reply 8: We have modified our text as advised (see page 6, line 114-115)

Comment 9: In table.1 History of TURBT is quite low. Why? Were most of patients diagnosed as invasive bladder cancer without TURBT?

Reply 9: The indications in our research not only included muscle-invasive bladder cancer, but also T1G3 and extensive papillary tumor as well. As presented in Table 3, Ta-T1 accounted for nearly 35% of all the cases. Part of the patients were diagnosed through cystoscopy and pathological biopsy, and together with CT or MRI, not TURBT. And as this is a retrospective study and many patients came from other hospitals, there could also be data omission as well. So accurately speaking, the rate of TURBT was at least 47.9%.