

# Peer Review File

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## Reviewer A

This article is a case report of ureteral fibroepithelial polyp treated with endourological surgery. In general, because the disease is different to be distinguished from urothelial cancer preoperatively, it is very important whether the affected kidney is successfully preserved, or not. However, there are some issues to be addressed.

### Major

Comment 1: There are several similar case reports or case series in which ureteral fibroepithelial polyp including cases with protrusion from ureteral orifice to bladder cavity which were successfully treated with holmium laser. The authors should clearly demonstrate the novelty and importance of this paper.

Reply 1: Thank you for your kind comment. As you mentioned, there are several similar case reports or case series for ureteral fibroepithelial polyp, which were successfully treated with holmium laser previously.

This article reported the ureteral fibroepithelial polyp protruding into the bladder, which mimicked a bladder tumour. At the first visit, we performed the cystoscopy, which revealed an irregularly shaped large bladder mass, suggesting a benign or malignant bladder tumour. Similar to this, intravenous urography and computed tomography showed a large lobulated contour filling defect in the bladder, measuring about 4 cm, although it was accompanied by a suspected finding of a connecting piece into the left distal ureter, which was not clearly identified.

Based on this result of examinations, we weighed on the possibility that it was a bladder tumour that originated from the bladder. Therefore, we think there is a novelty in that it was seen as a benign or malignant bladder on initial examination.

Additionally, it should be noted that there is a possibility of a wrong diagnosis in cases where bladder masses are found and the ureteral orifice is not clearly identified on cystoscopic examination. In such cases, ureteroscopy is recommended for accurate diagnosis and the most suitable treatment, especially in suspicion of the existence of connecting part into ureter in the imaging study.

Changes in the text: We added phrases in text as you mentioned (see page 5, line 72-75 and page 9, line 184-188)

Comment 2: Details of postoperative course including the change in renal function should be described in Case Presentation.

Reply 2: As you advised, we have added the postoperative course, including the change in renal function.

Changes in the text: We added phrases in the text as you advised. (see page 6, line 92-94)

Minor

Comment 1: Urgency and frequency are not voiding symptoms but storage symptoms. Descriptions in Case Presentation and Discussion should be corrected.

Reply 1: As you advised, we have corrected the descriptions in Case Presentation and Discussion.

Changes in the text: We modified phrases in the text as you advised. (see page 7, line 125)

Comment 2: Please spell out “YAG” in L.37 and L.82, and “FEP” in L.168

Reply 2: As you mentioned, we have spelt out “YAG” in L.38 and L.84-85 and “FEP” in L.168.

Changes in the text: As you mentioned, we have modified phrases in the text. (see page 2 line 34-35, see page 5 line 81-82, see page 9 line 174)

Comment 3: What does Fig 1B indicate? Resolutions of Fig 1A and B are low, and Fig 1A is similar with Fig 3A. Therefore, Fig 1 can be omitted.

Reply 3: Thank you for your comment. Fig 1B indicates a large polypoid mass in the bladder on cystoscopy, as Fig 1A on another side.

As you pointed out, the resolutions of Fig 1A and B are low; therefore, we improved those as much as possible.

Fig 3A shows a long and narrow tumour in the left distal ureter protruding into the bladder cavity through the ureteral orifice on ureteroscopy. We intended to show a polypoid mass in the bladder on cystoscopy, which mimicked a bladder tumour in Fig 1A and B, and a tumour in the left distal ureter protruding into the bladder through the ureteral orifice on ureteroscopy in Fig 3A. I hope you agree with our consideration.

Changes in the text: We have improved the resolutions of Fig 1A and 1B and replaced them accordingly (see Fig 1A and 1B).

Comment 4: Fig 2A, C, and D are less informative. Instead, are there any impressive CT

images of ureteral lesion?

Reply 4: Thank you for your comment. Fig 2A (early excretory) and B (delayed excretory) shows contrast-enhanced abdominal computed tomography (CT) showing lobulated contour filling defect in the bladder with a suspected finding of a long stalk in the left distal ureter during the excretory phase.

Fig C demonstrates that the polypoid lesion was not definitely seen on the corticomedullar phase without enhancement.

Fig D represents Intravenous urography showing about 4 cm-sized large filling defects in the ipsilateral bladder wall.

We considered the figures as the best picture taken on CT scan and IVP for the ureteral lesion.

As we mentioned previously, there was a suspected finding of a long stalk in the left distal ureter on the CT scan, but that was unclear. I hope you agree with our stand point.

**Changes in the text: We added the descriptions in Figure legends (see page 13, line 256-257)**

Comment 5: In L.83, “(Figure 3)” should be deleted, because Fig 3 did not include the scene of laser illumination.

Reply 5: As you mentioned, we have deleted the phrase in the text.

**Changes in the text: We deleted the phrase in text. (see page 5 line 82)**

Comment 6. In Fig 4, measure scale is included, and staining is described in the legend. Is hematoxylin and eosin staining employed?

Reply 6: Thank you for your comment. As you mentioned, hematoxylin and eosin staining

was applied on pathological examination. We add the staining method and indicator of a length of the tumor.

Changes in the text: We have added the descriptions in Figure legends and indicator of a length of the tumor in Figure. (see page 13, line 268-270 and figure 4).

Comment 7. Please correct the duplication of References.

Reply 7: Thank you for your comment. As you mentioned, we have removed the duplication of References.

Changes in the text: We removed the duplication of References.

## **Reviewer B**

This was a case report of a 49-year-old female who presented with urinary frequency and hematuria, and workup showing a bladder mass; there was suspicion that the mass actually originated from the distal ureter based in imaging studies and this was confirmed on ureteroscopy. The mass was removed during ureteroscopy by cutting the stalk of the mass that was located in the distal ureter; the mass was confirmed to be a fibroepithelial polyp and there was no recurrence based on CT scan one year after surgery.

Fibroepithelial polyps are rare, benign lesions of the urinary tract and there are certainly many case reports in the literature; however, this case report shows the even rarer instance of this benign tumor presenting as a bladder mass; there was suspicion that the origin of the

tumor was actually in the distal ureter and the authors appropriately performed ureteroscopy and using a laser, cut the stalk of the tumor. The authors then go on to discuss the incidence, pathogenesis, diagnosis and treatment, emphasizing that in the modern era, endoscopic treatment has been more frequent than open surgery.

This was a large fibroepithelial polyp emanating from the ureteral orifice; I personally have seen smaller fibroepithelial tumors that originated from the distal ureter that was only visualized emanating from the ureteral orifice with peristalsis of the ureter.

Comment 1: On line 84, “end-block” should be “en bloc” or “en-bloc.” In terms of other improvements, the preferred term for TCC is UC (urothelial carcinoma) – lines 130 and 133. On line 168, they use “FEP” which I assume is fibroepithelial polyp. They should define the acronym at the first instance of use.

Reply 1: Thank you for your comment. We have modified phrases in the text as you advised.

Changes in the text: We modified phrases in the text. (see page 5 line 83, page 7 line 136-137, page 8 line 140, page 9 line 174)

## **Reviewer C**

Comment 1: The cystoscopy showed "large bladder mass" was this the fibroepithelial polyp? Souds like there are two lesions - was there another finding besides FEP? The imaging section could be revised.

Reply 1: Thank you for your comment. We performed the cystoscopy, which revealed an irregularly shaped large bladder mass, suggesting a benign or malignant bladder tumour.

However, on following ureteroscopy, we confirmed that the large bladder mass was a ureteral fibroepithelial polyp protruding into the bladder, which mimicked a bladder tumour.

Fig 1A and 1B indicates large polypoid mass in the bladder on cystoscopic examination.

Fig 3A shows a long and narrow tumour in the left distal ureter protruding into the bladder cavity through the ureteral orifice on ureteroscopy.

**Changes in the text: We improved the resolutions of Fig 1A and B as much as possible for better understanding.**

Comment 2: Line 108 should have a reference and line 109.

Reply 2: We have added a reference to that part, as you mentioned.

**Changes in the text: We added a reference in the text as you advised. (see page 7, line 116)**

## **Reviewer D**

Comment 1: Take the word "Herein" out of the conclusion.

Reply 2: Thank you for your comment. As you advised, we have deleted the phrase in the text.

**Changes in the text: we deleted the phrase in the text. (see page 9, line 181)**