Peer Review File

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Reviewer A

Comment 1: The current WHO classification name for the entity referred to as "congenital fibrosarcoma" is "infantile fibrosarcoma." Please use the latter name for clarity.

Reply 1: Thanks for your advice. We changed the “congenital fibrosarcoma” to "infantile fibrosarcoma" in the “Introduction”, as advised, (see page 5, lines 8 and 9).

Comment 2: The description for WT1 IHC should indicate whether the staining was diffusely nuclear, cytoplasmic, or both.

Reply 2: Yes, thank you for your comment. WT1 IHC showed a diffusely nuclear staining positivity pattern, and the description was added in the “Case presentation” as recommended, (see page 7, lines 19 and 20).

Comment 3: VIM IHC should be referred to as vimentin for clarity.

Reply 3: Thanks for your correction. We changed the VIM to vimentin in the “Case presentation” and “Figure 3 legend”, accordingly, (see pages 7, line 19), and Figure 3 legend (page 17, line 5).

Comment 4: The description for p53 IHC in the text should indicate what the pattern of staining was. Heterogeneous staining generally implies the absence of a p53 mutation, whereas strong, diffuse staining or completely absent staining is seen in cases with p53 mutations.

Reply 4: Yes, thank you for your valuable comment. P53 IHC showed a heterogeneous staining and that was described in the “Case presentation”, (see page 7, lines 20,21).

Comment 5: In the description and figure legend, cyclin D1 is misspelled "CylinD1."

Reply 5: Yes, thanks for your correction. We corrected “CylinD1” to “cyclin D1” as a response to the above comment, in the “Case presentation”, (see page 7, line 21) and Figure 3 legend (page 17, line 6).

Comment 6: In line 185 of the discussion, "recommendable" should be replaced by "recommended."

Reply 6: Yes, thanks. We have changed “recommendable” to “recommended” in the “Discussion and review of the literature”, as advised, (see page 8, line 18).

Reviewer B

Comment 1: The prenatal description of the case is very poor. There are not descriptions of maternal and obstetrical history as well as the first and second trimester scans.

Reply 1: Yes, thanks for the valuable comments.

Maternal and obstetrical history: actually, during a routine ultrasound examination in a local private clinic for a nulliparous 36-year-old woman with natural pregnancy and at 36-week of her gestation, she was found to have a fetus with an abdominal mass and was then referred to our hospital. Apart from the increasing fetal abdominal mass, the woman had uneventful maternal and obstetric history with unremarkable previous US results, and she denied any exposure to chemical or radioactive materials. Down's screening and oral glucose tolerance test showed no abnormality. Before proceeding to the MRI, another US was performed in our hospital at 36 weeks’ gestation and showed an increased amniotic fluid index (AFI) of 19.3 cm, along with the confirmation of the fetal abdominal mass.

The first and second trimester scans were uneventful. Also, her routine follow-up and previous ultrasounds were recorded as unremarkable. Indeed, the diagnosis of the mass was just detected at the 36-week of gestation by a routine ultrasound.

According to your important comments, we did make some changes to the description of maternal and obstetrical history in the “Case presentation” in reference to the available information by writing the following text: (During a routine US examination, a 36-year-old nulliparous woman with natural pregnancy at 36-week of gestation was found to have a fetus with an abdominal mass. Apart from the increasing fetal abdominal mass, the woman had uneventful maternal and obstetric history with unremarkable previous US results, and she denied any exposure to chemical or radioactive materials. Before proceeding to the MRI, another US was performed in our hospital at 36 weeks’ gestation and showed an increased amniotic fluid index of 19.3 cm, along with the confirmation of the fetal abdominal mass). (See page 5, lines 23-25 and page 6, lines 1-5).

Comment 2: The diagnosis of fetal abdominal mass are possible from the mid second trimester scan. Why the diagnosis was performed too late (36 weeks)?

Reply 2: Yes, thanks for your interesting comment. As we showed in the "Discussion and review of the literature" that the earliest fetal CMN detected by MRI was at 22+3 weeks of gestation and was of classic subtype (Table 1, reference 17), and such early detection could be mostly attributed to the large mass along with hydrops fetalis, and the patient died soon after delivery in the 25-week of gestation (see the discussion page 9, lines 14 and 15). While in eight of 10 CMN cases (Table 1 and 2), the diagnosis was made in the third trimester, with a mean of 33 (27-36) gestational weeks (see the discussion page 9, lines 16 and 17). Although it was a bit late, the diagnosis of our patient was within the spectrum of (27-36). Furthermore, it was mentioned that only about 15% of CMN cases could be diagnosed prenatally (see the introduction; page 5, line 16), and among those diagnosed postnatally, cellular CMN was shown to be significantly associated with higher age at presentation (usually in infancy), whereas classic CMN was usually detected earlier in the neonatal period (References 1 and 3).

Comment 3: What was the gestational age of delivery?

Reply 3: Thank you for your question. Maybe it was not clear, as we only mentioned it in Table 2 under the title of our (current report), sorry for that. Therefore, we changed the paragraph in the "Case presentation" to make the gestational age clear, and instead of full term, we wrote 38-week gestation as shown (A boy weighing 3,560 grams was born via elective Cesarean-section at 38-week gestation, with Apgar scores of 9 and 10 at 1 and 5 minutes, respectively). (See page 6, lines 16 and 17).

Comment 4: Was the renal biopsy performed?

Reply 4: Thank you for this question. In fact, the renal biopsy was not performed, as an immediate nephrectomy was planned. Given that the non-invasive imaging results were shown to be correlated with the pathology according to previous studies, were considered the (prenatal US and MRI along with the postnatal US and CT) of our case as the references for making the decision of surgery (see page 10, lines 8-13). Also, the paragraph (It is also recommended that all primary renal tumors diagnosed in infants younger than 6 months should be treated with immediate nephrectomy), (see page 8, lines 18-20). (References 2, 3 and 8).

Comment 5: Neuroblastoma is a common abdominal mass in the prenatal period. The authors should show the differences in the MRI findings compared to CMN.

Reply 5: Yes, thank you very much for your notification, it was important to mention

it. Therefore, we added the following texts to expand the spectrum of our differential diagnosis, and include neuroblastoma, with a highlight on the points of difference in MRI features of neuroblastoma compared to CMN.

We added the sentence (whereas the main nonrenal differential diagnosis is neuroblastoma), (see page 8, line 6 and 7). And the paragraph (Prenatal MRI finding in CMN albeit nonspecific, it generally shows a well-defined, homogeneously solid mass, and tends to be isointense to normal renal parenchyma on T2WI (6). On MRI the tumor can be distinguished from fetal kidney and adrenal gland4, therefore, a congenital neuroblastoma, which arises mostly from adrenal gland, can be identified. Remarkably, encasement of the adjacent structures and blood vessels, in addition to calcification that can be seen as blooming artifacts in MRI, are features of neuroblastoma but not CMN). (See page 8, lines 8-14).