Peer Review File

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Reviewer comments

Reviewer A

Yamauchi et al present an interesting case of a mediastinal Mullerian cyst resected with robotic techniques. The robotic aspect of the case is fairly straightforward. The appeal of this case report lies in its presentation of an unusual entity. Comments/questions below:

Comment 1: More detail regarding the robotic performance of this operation is justified. Please specify number and location of ports, instruments used, duration of operation, chest tube management, postoperative hospital stay.

Reply 1: We thank reviewer A for his/her important comments. Four ports were installed at the sixth intercostal space. Maryland bipolar forceps, Fenestrated bipolar forceps and Cadiere forceps were used. Surgical time was 1 hour, and console time was 24 minutes. A 20 French trocar tube was placed at the end of surgery. The chest tube was removed on the second postoperative day after confirming the absence of chylothorax. The patient was discharged on the third postoperative day.

Changes in the text: We have modified our text as advised (see Page 4, line 67-74).

Comment 2: Did the patients' symptoms improve after resection?

Reply 2: The patient had no symptom just before the resection. Back pain was diminished beforehand. Therefore, no improvement of symptoms was found.

Changes in the text: We have modified our text as advised (see Page 4, line 61-62).

Comment 3: Were there any radiologic clues, in retrospect, that were characteristic of Mullerian cyst?

Reply 3: We believe that if a cystic lesion with a thin cystic wall is found in the posterior mediastinum adjacent to the thoracic vertebral body, this disease should be listed as a differential.

Changes in the text: We have modified our text as advised (see Page 7, line 122-124).

Comment 4: Often it is simpler to drain cysts to facilitate removal, and frequently cysts will rupture during handling. Is there any disadvantage to draining a cyst like this during resection?

Reply 4: If the cyst had been larger, it might have been easier to handle after the contents were expelled, but in this case, it was not difficult to handle the cyst without damaging the cyst wall, thanks to RATS technology. In addition, although it may not be a major advantage, we believe that it was easier to reach an accurate diagnosis in this case by not damaging the cyst wall, i.e., not damaging the single layer of ciliated columnar epithelium.

Changes in the text: We have modified our text as advised (see Page 6, line 86-90).

Comment 5: This case brings up the interesting possibility that Mullerian cysts may be misdiagnosed as bronchogenic or other cysts. Did the pathologic appearance of the Mullerian cyst differ from that of other non-Mullerian cysts? If not, how did the pathologists know to do the immunohistochemical staining to assess for Mullerian cyst? Are there any special considerations with regards to follow up imaging/surveillance or gynecologic management in patients found to have a Mullerian cyst?

Reply 5: There is no significant difference between Muller cyst and non-Muller cyst in HE-staining. Therefore, based on our experience, we would like to advise that clinicians should list Mullerian cyst as one of the possible diagnoses when the cyst is located in the posterior mediastinum, especially when it is adjacent to the thoracic vertebral body. Also, when Mullerian cyst is listed as one of the possible diagnoses, immunohistological staining should be considered for a definitive diagnosis.

Changes in the text: We have modified our text as advised (see Page 7, line 121-126).

Reviewer B

Comment: Thank you for reporting the case of RATS resection of a mediastinal Müllerian cyst. It is an interesting case; the report is well-written and relevant for thoracic surgeons.

Reply: Any further comments or advice would be greatly appreciated.