Peer Review File

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Reviewer A

Overall, an interesting read with minor revisions needed:
1. Please ensure appropriate citations are used, for example in lines 11-13, though multiple studies are referenced, only one is cited.

Reply 1:
Thank you very much for your comment. We have revised the reference to be appropriate.

Changes in the text (page 5, line 10)
Various benign glandular lesions, including cystitis glandularis, should be considered in the differential diagnosis of bladder adenocarcinoma.[4-7] Cystitis glandularis, a relatively rare condition of proliferative cystitis, is generally classified into two categories: 1) usual/typical and 2) intestinal (also known as intestinal metaplasia).[6]

2. Please double-check all figure legends. It appears that legend 1 may have mixed up panel labeling and legend 2 is incomplete. Further, images repeat between figure 1 and figure 2.

Reply 2:
Thank you very much for your comment. We have deleted Figure 2 because Figure 2 is just an expansion of Figure 1. We have corrected the figure 1 panel labeling.

3. Please provide IHC images for other stains.

Reply 3:
Thank you very much for your comment. We have added IHC images for CK7, CK20, CDX-2, and β-catenin in Figure 2(A-D).

4. Please clarify what is being reported. The authors state that this is a report of bladder carcinoma associated with intestinal metaplasia and cystitis glandularis, however, this is part of the differential diagnoses.

Reply 4:
Thank you very much for your comment. The final diagnosis of this case was adenocarcinoma, NOS, associated with intestinal metaplasia and cystitis glandularis. The final diagnosis was described in page 6, line 19.

The final pathological diagnosis was adenocarcinoma NOS associated with intestinal metaplasia and cystitis glandularis.

5. Please provide follow-up care for the patient.

Reply 5:
Thank you very much for your comment. The follow-up care was described in page 7, line 8.

The patient had the periodic cystoscopy, urine cytology, and computed tomography and was free from recurrence one year after the surgery.

Reviewer B

The authors present the case of a patient with a bladder adenocarcinoma associated with intestinal metaplasia and cystitis glandularis, an uncommon pathology. The writing is adequate and adapts to the editorial characteristics of the magazine. The bibliographic review is extensive and includes recent publications that allow for an appropriate discussion. It would be illustrative to include an image of diagnostic cystoscopy as well as robotic surgery performed to assess its acceptance. However, it is a case with a single patient (n=1) with limited scientific power.

Reply:
Thank you very much for your comment. We provide the cystoscopy image in Figure 1A. We omit images of robot-assisted radical cystectomy because the images are not specific and not informative. Thank you very much for your understanding.
The limitation of our study is that this is a single case report. We have added the following sentence in page 9, line 17.

As this is a single case report, accumulation of similar case reports would improve the treatment of patients with bladder adenocarcinoma.

Reviewer C

This is an excellent case.
The other interesting point about this case is that in spite of adenocarcinomas having a poor prognosis, this patient got the surgery immediately which resulted in no recurrence till 1 year.
The grammar could be improved.

Reply:
Thank you very much for your comment. We had this manuscript re-checked by English natives.

Reviewer D

This is a review of an adenocarcinoma found within cystitis glandularis / intestinal metaplasia that was managed with TURBT and subsequent robotic cystectomy. This is well written and clear.

That cystitis glandularis is a premalignant lesion is controversial as the authors assert. However, this is not the first time adenocarcinoma arising from a background of cystitis glandularis has been reported, the first was in 1964 I think (see Kittredge et al in the Journal of Urology) and there have been more since. In addition, part of the standard diagnostic criteria for urachal adenocarcinoma is the absence of cystitis glandularis (because that would be more likely to be associated with a primary bladder adenocarcinoma). Thus, in itself, this is not novel. This appears to be a very early stage adenocarcinoma that was appropriately managed aggressively by cystectomy rather than TURBT alone. The robotic approach is novel and carries some risk whenever dealing with a rare aggressive cancer like bladder adenocarcinoma - this deserves further discussion regarding pluses and minuses of such an approach, especially as this is a surgical journal.

Reply:
Thank you very much for your comment. We totally agree that adenocarcinoma arising from a background of cystitis glandularis is not new. As you pointed out, our case was at a very early stage of adenocarcinoma. We have added the following sentences in the discussion (page.9, line 14)

Although robot-assisted radical cystectomy has been replacing open or laparoscopic

radical cystectomy, there are some reports on atypical recurrence of bladder cancer after RARC.[15] Surgical indication should be limited to tumors at early stages.