TCR TRANSLATIONAL CANCER RESEARCH
ADVANCES CLINICAL MEDICINE TOWARD THE GOAL OF IMPROVING PATIENTS' QUALITY OF LIFE
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Peer Review File

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Reviewer A

Comment 1: Authors should describe clinical and pathological details of primary renal cell carcinoma. (ex. cT1a? or T1b?, clear cell renal cell carcinoma with what Fuhrman grade?)

Reply 1: Thank you for this comment. We are very sorry for our negligence. We added clinical and pathological details of primary renal cell carcinoma (see Page 4, line 79).

Changes in the text: The clinical stage of RCC with Fuhrman grade 3 (Figure 1) was stage I (T1b, N0, and M0), according to Tumor, Node, Metastasis (TNM) classification (see Page 4, line 78-80).

Comment 2: In page5, line 94-96 “That could be at least partially due to the right renal vein being shorter than the left side. Right kidney cancer may be more likely to metastasize through inferior vena cave to the digestive organs than the left.” Is that really? It is not known generally in urological world. As far as I looked for the papers which concerned about laterality of renal cell carcinoma, I could find the opposite opinion in this paper. (Guo S, Yao K, He X et al. Prognostic significance of laterality in renal cell carcinoma: A population-based study from the surveillance, epidemiology, and end results (SEER) database. Cancer Med. 2019 Sep;8(12):5629-5637. PMID: 31407495 doi:10.1002/cam4.2484) In this population-based retrospective study, right-sided renal cell carcinoma had better CSS than left-sided. Moreover, their analysis suggested that left-sided renal cell carcinoma frequently metastasize to lung with reason of more vascular collateral circulation in the left renal vein.
If authors going to express the opinion that “right-sided renal cell carcinoma more frequently spread to digestive organs than left-sided.”, please show some rationale.

Reply 2: We are very sorry for our incorrect writing. Most of the duodenal metastasis of RCC occurs after right kidney nephrectomy, but the mechanism is unclear. We only get this rule in a few cases, but the mechanism still needs further study. We also have removed previous immature expressions (see Page 7, line 135-140).

Changes in the text: The findings of the present case study, along with some other studies, indicated that most of the duodenal metastasis of an RCC occurs after right kidney nephrectomy. However, the mechanism is poorly understood (see Page 7, line 131-134).

Comment 3: Please discuss about the metastatic rate and epidemiology of late onset pancreatic metastasis. If it works for you, please check this paper as a reference. (Noguchi G, Nakaigawa N, Taguri M et al. Time-dependent change in relapse sites of renal cell carcinoma after curative surgery. Clin Exp Metastasis 2018 Feb;35(1-2):69-75. PMID: 29516208 doi:10.1007/s10585-018-9883-0)

Reply 3: Thank to the Reviewer's suggestion, the paper is very helpful to us. We added characteristics of metastatic rate and epidemiology of late onset pancreatic metastasis (Page 6, line 121-124).

Changes in the text: Clear cell RCC showed potential to relapse beyond 10 years after surgery (3). Recurrence of tumors at typical sites decreased, whereas retroperitoneal organ recurrence increased in a time-dependent manner, with a pancreatic metastasis rate of 2.7% (3) (see Page 6, line 121-124).

Comment 4: An English revision must be carried out.
Reply 4: We are very sorry for our negligence of language accuracy. An English revision has been carried out by a native English-speaking expert who is majoring in my field.

Reviewer B
Comment 1: The description of the case is well done but the case does not add new information about the unusual presentation of renal cancer. Mousa OY reported 4 patients with periampullary or pancreatitic metastatic disease following complete resection of RCC.
Mousa OY, Shah R, Hajar N, Landas SK. Periampullary and Pancreatic Metastases of Renal Cell Carcinoma: An Underdiagnosed Event. World J Oncol. 2015;6:378-380

Reply: Thank you for this comment. In other case reports, patients were given further treatment after surgery. However, due to economic conditions, in this case, the patient did not undergo chemotherapy and immunotherapy, but undergone metastasis until the 17th year after surgery. After metastasis, the patient was only given palliative

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treatment. Four years later, the patient was still alive. We have re-written this part according to the Reviewer's suggestion (see Page 7-8, line 147-154)

Changes in the text: For any RCC patient with pancreatic or duodenal metastasis, if feasible in med-icine and technology, surgery is the best option to choose, because it seems to pro-long the disease-free survival (4,20). However, multiple metastatic lesions carry a worse prognosis than solitary ones (4). Previous studies have found that the average survival time of patients with disseminated malignant tumors is about 4 months, and generally, only 10% of them can survive for 1 year (4). However, in the present case study, the patient still survived for 4 years after the detection of metastases. The rea-son is unclear and needs further study (see Page 7-8, line 147-154)