Peer Review File
Article information: http://dx.doi.org/10.21037/amj-20-191.

Review A:
This is a comprehensive, well-organized review of VUAS. just needs a bit of polishing and updating.

my Comments below:

Comment 1: title - the majority of the review is not about the devastated outlet, but VUAS only, would drop "the devastated outlet" or concentrate/focus more on the recalcitrant part
VUAS is preferred term now, perhaps just drop BNC altogether?

Response 1: I feel like the review is about both VUAS (stenosis after prostatectomy) and BNC (stenosis with prostate still in situ), but I agree – not about the devastated outlet as an entity. Changed to focus on the recalcitrant stenoses part

Comment 2: introduction - paragraph 3 would be better served in discussion

Response 2: agree – changed as per reviewer Comments

Comment 3: 4.2 did you mean temporary suparvesical diversion?

Response 3: yes – changed as per reviewer Comments

Comment 4: 4.2 a brief discussion on the outcome of prior treatments and how that drives future treatment. is the patient totally incontinent after dilation? that should guide the surgeon toward selection of the surgical intervention

Response 4: changed as per reviewer Comments

Comment 5: 4.3.1 do the authors recommend use of the off-label vascular stent?

RESPONSE 5: yes, in some situations. Changed as per reviewer Comments

Comment 6: 4.3.1 Transurethral incision with transverse mucosal realignment for repair of posterior urethral strictures, technique and early outcomes, Warner, Urology video journal should be included

Response 6: changed as per reviewer Comments

Comment 7: 4.3.2 discussion of preoperative continence and location of stenosis should be included. those patients already incontinent and with stenosis above the per-

ineal membrane may benefit more from robot VUAS repair or a non-perinal approach. additonally, it should be noted the higher AUS erosion/revision rates in patients s/p perineal repair of VUAS.

Response 7: changed as per reviewer Comments

Comment 8: 4.3.3 mention of buccal graft via robotic approach (transvesical and transabdominal) should be included

Response 8: changed as per reviewer Comments

Comment 9: 4.3.4 discussion regarding the defunctionalized bladder should be included

Response 9: changed as per reviewer Comments

Comment 10: 4.3.4 is there data to support the statements:
a. supravesical diversion is less morbid than reconstruction
b. conduit or pouch is better in the radiated patient than augment

Response 10: changed as per reviewer Comments

Comment 11: 4.3.4 what is the difference between supravesical diversion and reconstructive surgery? i think i know what you mean, but this is not clear, especially since spt is lumped in with supravesical diversion

Response 11: I understand your confusion… section changed as per reviewer Comments

Comment 12: 4.3.4 major multiple surgeries -> multiple major surgeries

Response 12: changed as per reviewer Comments

Comment 13: 4.3.4 discussion of ureteral anastomsis techniques and use of ICG in radiated patients is warranted

Response 13: changed as per reviewer Comments

Review B:

Refractory BNC/VUAS after localized prostate cancer treatment is an extremely difficult clinical problem to manage and the authors highlight the different treatment options available to address this. Although it is well written and easy to follow, it is lacking as a comprehensive narrative review.

Comment 1:
Diagnosis and Evaluation section
It is somewhat misleading to the reader to say that RUG +/- VCUG "should" be performed. For a contracture that is clearly seen on cystoscopy to be truly limited to the bladder neck and is not involving the entire posterior urethra, RUG/VCUG is not necessarily needed. Also, RUG by itself is a poor imaging modality for visualizing the posterior urethra. Figure 1 confirms this point.

Response 1: changed as per reviewer Comments

Comment 2:
Treatment section
When quoting 97% dilation or incision success when allowing for multiple attempts, it is important to put these numbers into context with regard to the variable follow up among studies reviewed and to inform the reader what the definition of success is in this setting. With regard to the quoted 100% eventual success of a deep TUIBN, this does not represent all literature. The referenced Ramirez et al study on deep TUIBN does not show a 100% eventual success rate.

Response 2: changed as per reviewer Comments

Comment 3: If ISD is used after dilation or urethrotomy, is that dilation/incision still considered successful? Also, is it reasonable to compare success rates of a single open/robotic procedure vs. the success rates of endoscopic techniques (if allowing for multiple attempts)? Many would argue no to both questions. More clarity and caution is needed in this section to better educate the reader on what "success" means and not inappropriately present the long-term expected success of endoscopic techniques in this setting, given the limitations of the literature reviewed.

Response 3: changed as per reviewer Comments

Comment 4: In the paragraphs on robotic approaches, the V-Y plasty is one of several described techniques in this setting. A more comprehensive review is needed.
Response 4: changed as per reviewer Comments