ANSWER TO PEER-REVIEW REPORT 1

In the Abstract it is said "The preoperative clinical diagnosis was renal pelvic carcinoma, determined by imaging examination and biopsy." While in the script there is no mention of RCC in initial biopsy Was the tumour taken out cleanly with clear margins?

ANSWER: The most common type of renal pelvic carcinoma is urothelial carcinoma, not renal cell carcinoma.. Preoperative diagnosis of renal pelvic carcinoma in this patient was due to the fact that the tumor was located in the left renal pelvis and upper ureter, and the possibility of renal pelvic carcinoma could not be completely excluded by pathological examination of the biopsy sample. During operation, the tumour was resected cleanly with clear margins,which was identified by the later pathological result. I also have added this to the manuscript and highlighted.

There is now coming data of TKIs in the management of Myofibroblastic tumours These tumours have a high recurrence rates so: - Is there a role for any Adjuvant treatment in high risk tumour of > 5 cms? - How frequently you recommend to be followed and by what methods (CT, MRI, Clinical, USG)

ANSWER: It was recently reported that Myofibroblastic tumour patients had promising results with crizotinib treatment, so TKIs can be used as an alternative to conservative treatment. For tumors that are difficult to completely resect, TKIs can be also used as neoadjuvant therapy. However, since in most cases the prognosis of renal PMPs is good, TKIs adjuvant therapy after operation is not recommended routinely. According to our experience, It is recommended that CT examination be performed 3-mo or 6-mo in the first two years after operation, if nothing special found in the CT result，the re-examination time may extend to every 6-mo or 1 year afterwards. For patients undergoing partial nephrectomy, CT examination is also recommended 1-mo after operation. These contents have been added to the manuscript and marked red.

ANSWER TO PEER-REVIEW REPORT 2

Comments on the manuscript 47329 entitled: "Organ-associated pseudosarcomatous myofibroblastic proliferation with ossification in the lower pole of the kidney mimicking renal pelvic carcinoma: A case report" Organ-associated pseudosarcomatous myofibroblastic proliferation is a type of benign tumor involving mainly the urinary bladder. In this manuscript, the authors describe a rare case involving the kidney. This well written report is useful and well described. Nevertheless, before publication I propose some improvements. Some specifications about the histological examination lack and would be useful: - What was the fixative? - For immunohistochemical visualization, specify the nature of antibodies, how was performed the staining, what was the amplification method used, What was the chromogen used? What were the negative controls?

Answer: The specimens studied were formalin fixed and paraffin embedded. Only blocks containing the advancing edge of the primary tumor were evaluated. Tissue sections of 5-µm thickness were cut onto glass slides, dewaxed in xylene, and rehydrated through graded alcohols before antigen retrieval by microwave treatment in citrate buffer (pH 6.0). then incubated with anti-calponin (1:100,ab46794, Abcam), Anti-SATB2 (1:100, ab51502; Abcam), anti-Ki67 (1:100, A11005; Abclonal), anti-CK (1:100, ab219077; Abcam) and anti-P16 (1:4000, ab54210; Abcam). PBS instead of the primary antibody was used as the negative control. Immunostaining was performed using the Envision System with diaminobenzidine (Dako Cytomation, Glostrup, Denmark). Images were viewed and assessed using a microscope (KF-PRO-005, Kfbio, China).

Figures 1A and 1B: indicate with arrows the mass observed with computed tomography and the calcified mass visualized with resonance imaging. Figures 2C and D: indicate with arrows the labeled cells.

Answer: Arrows have been marked in the Figures of the manuscript.