

Dear editors,

Thank you for taking your time to give us the opportunity to submit a revised draft of our manuscript titled *unspecified live kidney donation by urological patients*. We are grateful to the reviewers for their comments on the paper and have been able to incorporate most of the suggestions provided by the reviewers.

Comment 1: *Ceuppens et al presented 9 case series of patients with urological complications who donated kidney and had good outcomes in the recipient and also in the donor. I am not sure how with this small sample size we could make some definite recommendations or conclusion. I have some other concern too. 1. I see 3 of the patients had nephrectomy for kidney stones, Nephrectomy for kidney stones are not common practice. Was these nephrectomy done only for the donation or was it planned for nephrectomy already (regardless of donatation) 2. In current era, I believe none of the transplant center will allow patient to donate kidney with multiple/recurrent or symptomatic kidney stones 3. Were donor given options for 3 other methods as explained by the authors- including auto transplant, discard, kidney donation 4. Were recipients made aware of these type of kidney? 5. Which year were this transplant performed? 6. Does patient with renal infarction need nephrectomy? And if they need, is it good idea to transplant this kidney to someone.*

Response: we understand the confusion on point 1,3,4 and 5 and have tried to clarify this in the manuscript. Regarding point 2 we believe it is slightly out of scope because of the point we are trying to make in this article that transplant centers instead of not transplanting those kidneys should transplant them because of the good outcome they give.

Comment 2: *Dear Editor, As a reviewer, I read the article carefully and also the comments of the other reviewers. It surprised me to see other reviewers' quick judgment on rejecting the manuscript. One reviewer wrote: "I believe your final conclusion is over-reach because it was such a small sample size (9 cases) it is very hard to draw a positive or negative conclusion." This comment is irrelevant. I would like to assure you that this is a very important concept. The huge supply and demand gap in organs prevents many patients from receiving life-saving organs. Any source to close this gap is of utmost importance, no matter how big or small. This case series is presenting successful transplants of 9 kidneys. Since this is a novel concept, I can say that this is enough to make a smart conclusion. My profession is general surgery and as a part of our multidisciplinary transplant team, I perform kidney transplant surgeries under the department of urology with my husband who is an academic urologist. It has been more than a few times now, we have found ourselves removing a kidney from a urological patient and asking immediately, would there be anyone in our kidney transplant waitlist who would have benefitted receiving this kidney? This retrospective research article gives us, the transplant community, the answer for just that, without getting into too much detail. You see, there is a risk-benefit ratio for every individual in every unique clinical scenario. Rarely, but surely there are cases where we do choose not to autotransplant the kidney we removed, or regret doing it afterward. There is a whole series of kidney transplants reported from Australia, where kidneys with tumors have been removed from urology patients. These kidneys were taken to the bench and their tumors were removed followed by successful transplants to patients on the waitlist. (Outcomes of transplants from patients with small renal tumors live unrelated donors and dialysis wait-listed patients, Nicholas R. Brook, Norma Gibbons , David W. Johnson , David L. Nicol. First published:06 April 2010. <https://doi.org/10.1111/j.1432-2277.2009.01002.x>. Citations: 19) In routine urology practice, many kidneys are being removed due to innumerable disorders. In this scarcity of transplantable organs, we should investigate every kidney that has been removed with the eye of a transplant surgeon. The transplant surgeons truly know and are aware of the declining quality of current donor resources. They also know how patients suffer from dialysis and die with an expect to receive an organ. I hope this study gets published at The World Journal of Transplantation and leaves the readers with more questions in mind. I would kindly ask you to send this article to be reviewed by true experts in the field. Additionally, I would prefer to follow-through this article `s progress, if any changes will be made during evaluation and would be happy to provide my view on it if needed again. Thank you. Kind Regards.*

Response: thank you for your revision. We have further emphasized the scarcity of transplantable organs and that investigation of kidneys normally discarded based on urological complications should be performed.

Comment 3: *Dear authors, thank you for submitting your paper to the World Journal of Transplantation. I understand that the study was a retrospective data review and analysis, but you used some language that implying you performed certain tests on the donors which in not the nature of retrospective study, it can be a misuse of terminology. Such as; (We conducted a mercaptoacetytriglycerine-3 scan), can you verify what you meant?. Although, you did conducted a sound review of the cases, I believe your final conclusion is over-reach, because it was such small sample size (9 cases) it is very hard to draw a positive or negative conclusion. It may be a good idea to consider in very special group of patients that can be used as a potential donor. Also, there is no propensity-matched analysis done to document what you mentioned in your conclusion due to small sample size. Regards*

Response: You have raised an important point here. We believe that since this is a relatively new concept such conclusions can be made in order to increase the donor pool. We have rephrased you comment on our terminology.