

Dear editor,

Many thanks for your kind advice about our manuscript. We have revised the aspects according to the reviewers' reports and submitted it again.

The corrections as suggested by the reviewers are carried out:

Reviewer #1:

1. This tumor is rarer than tumors that invade the inferior vena cava (IVC) or renal vein, and only a few cases of -----have been reported in the literature. Please provide references or this comments.

RE: Thank you for the nice advice. We had added relevant references in the new manuscript.

2. What were the clinical complaints of the patient? Why did he go for an ultrasound abdomen examination?

RE: Thank you for the nice advice. The patient took an abdominal ultrasound examination because of yearly routine physical examination and found an adrenal tumor. He declared any symptoms including hypertension, fever, headache or palpitation.

3. Was first surgery also a robotic one? If not why?

RE: Thank you for the nice advice. The patient underwent left laparoscopic adrenalectomy via retro peritoneal approach without using robot system. Because this surgery is well established and becomes standard treatment for adrenal tumors. And we did not recognize tumor thrombus in the renal vein before the first surgery. Thus we chose laparoscopic adrenalectomy for the first surgery.

4. "Given the anatomic differences of the left and the right adrenal vessels, nephrectomy is recommended when the tumor is on the left"- please explain it. Why is nephrectomy necessary when the tumor is on the left side? If this happens on right, is nephrectomy not needed? Please comment.

RE: Thank you for the nice advice. Venous drainage of adrenals varies by side. The

right adrenal vein directly enters the IVC. The left adrenal vein joins with the left renal vein and then enters the IVC. The tumor thrombus might extend into the left renal vein through adrenal vein from the left adrenal tumor. However, in this case, it was interesting that the tumor presented its “leaping growth” as no tumor thrombus found in adrenal vein.

Considering the difficulty of thrombectomy as the tumor thrombus was at the root of renal vein and probability of metastasis to the left kidney, nephrectomy was needed. If the tumor was at right side, tumor thrombus would directly extend into the IVC without invading the renal vein. Thus, nephrectomy is not needed if this happens on right.

5. Why did not you go for CT angiography to assess the vessels at the time of first surgery? This may have diagnosed the thrombus at the junction of renal vein and the IVC. Please comment.

RE: Thank you for your remind. CTA is not routinely accessed for patients with adrenal tumors. However, if we went for CTA before the first surgery, the tumor thrombus would be definitely diagnosed. And delayed detection of tumor thrombus would not happen. This reminds us that CTA is needed when considering tumor thrombus in vein.

6. Please mention as to how you would have avoided this problem at the time of first surgery. Was there any way out?

RE: Thank you for the nice advice. As mentioned, CTA could clearly show the artery and vein. Tumor thrombus would be definitely diagnosed and the patient could underwent adrenalectomy, nephrectomy and resection of tumor thrombus during one surgery. The renal contrast-enhanced ultrasound could also reveal tumor thrombus as did before the second surgery. IVC ultrasound or angiogram is also needed to detect whether tumor thrombus invade the IVC.

7. Conclusion can be rephrased. For example- “pheochromocytoma is a rare tumor,

and metastatic tumor involving renal vein and IVC is even rarer". It may be your language. My line is just a suggestion.

RE: Thank you for the nice advice. We had rephrased the conclusion part in the new manuscript.

Editorial Office's comments:

Thank you for all the advice. We had provided all the missing part and re-write the sections that need modification in the new manuscript.

Best Regards,

Authors