[Reviewer 1]

Dear Authors, The topic of your case report is interesting. Here are my comments.

1. Regarding CARE checklist - you wrote only Y?

→ Thank you for valuable comments. I corrected CARE check list.

2. The abstract is too short. You can extend it by adding more data. You can also use more keywords.

→ Thank you for valuable comments.

I expanded the abstract and keyword.

3. The case report section: - what type of CT you performed contrast enhanced (or not)?

→ Type of CT in my center is, of course, kidney dynamic computed tomography (three phases of intravenous contrast enhancement).

I added this point to the manuscript.

4. Why did you decide on performing the surgery on the same day (diagnosis and admission)?

→ At the time of his visit to emergency department, he had severe flank pain and gross hematuria, so we decide to perform emergency surgery rather than elective surgery.

I added this point to the manuscript.

5. You wrote: Biopsy showed pT3a clear cell RCC with Fuhrman grade III. You probably mean histopathological evaluation of the specimen or you took biopsies during the surgery?

→ Thank you for valuable comments. I revised the sentence.

6. During the surgery - you used endobag to remove the specimen or not?

→ During radical nephrectomy, of course, I routinely use endobag to remove the

specimen out.

I added this point to the manuscript.

7. Which approach you used to remove the specimen from the abdominal cavity (lower midline incision? left lower quadrant incision?)

→ Thank you for valuable comments.

I pierce a 12 mm camera port near the umbilicus.

When I remove the specimen, I open 12 mm camera port a little bit more and take it out from the abdominal cavity.

I added this point to the manuscript.

8. You wrote: Positron emission tomography/CT (Fig. 3) was performed immediately, and the results were the same (mild hypermetabolic nodule in the left lower peritoneum). What kind of PET/CT did you perform?

→ F-fluorodeoxyglucose (FDG) Positron emission tomography/CT was performed.

I added this point to the manuscript.

9. Fig 1. Please mark the tumor.

→ I've marked the tumor with an arrow

10. You wrote: No metastatic lesion was observed in the most recent CT scan. How recent is this CT scan? Please, explain how long after primary surgery you performed CT (it was just abdomen CT/CTU or you performed also CT of the thorax and head?)

→ Thank you for valuable comments.

The most recent brain, chest and abdomen CT was on July 5th, 2023.

In other words, the interval between the primary surgery and the most recent CT was 12 months.

I added this point to the manuscript.

11. Fig 2. Please mark the metastatic lesion.

→ I've marked the metastatic lesion with an arrow

12. Fig 3. Please mark the metabolic active node.

→ I've marked the metabolic active node with an arrow

13. When performing the second surgery how you identified the positive node? How you positioned the trocars (add more data about technical aspect of the surgery)?

→ Thank you for valuable comments.

The patient underwent the second surgery with supine position.

A 12 mm port was inserted just above the umbilicus, and other 12 mm and 5 mm ports were inserted at the RLQ and LLQ.

Fortunately, the node was visible as soon as we entered the abdominal cavity and node was able to be removed by the urologist without the help of a general surgeon.

14. Fig 4. It would be nice to have a ruler on 4A so we can see the size of the specimen; use asterisk, arrows to mark where are specific atypical clear cell nests, fibroadipose tissue.

→ Thank you for valuable comments.

I revised the Fig 4 as you pointed out.

15. Regarding therapy with pembrolizumab, did you decide on such treatment on multidisciplinary meeting? Was the patient seen by oncologist or just urologist? What is the duration/scheme of application of pembrolizumab? Does patient has any side effects so far?

→ Thank you for valuable comments.

In our hospital, immunotherapy or targeted therapy for RCC are entirely determined by urologists, not medical oncologists. Therefore, JWC decided to start the adjuvant pembrolizumab. Duration/scheme of application of pembrolizumab is intravenous injection every 3 weeks, with at least 10 administrations.

There were minor abnormalities on thyroid function tests, but the patient has not experience any side effect until recently.

I added this point to the manuscript.

16. Discussion: please comment on incidence of metastases of RCC in surgical wound through which specimen was removed/patient was operated.

→ Thank you for valuable comments.

① Port-site metastasis or peritoneal spread after laparoscopic surgery for urological malignancies is a rare phenomenon accounting for 0.09% and 0.03% of the cases respectively.

- PMID: 18279936

- PMID: 23632074

② RCC is the least of all urological malignancies in developing port-site metastasis or peritoneal spread, with only rare cases being reported in the literature.

- PMID: 18342166

I added this point to the manuscript.

[Reviewer 2]

This is a manuscript regarding a single omental metastasis of RCC after Lt radical nephrectomy. Omental metastasis is rare. Authors speculate that some tumorigenic but non-metastasizing neoplastic cells, which under normal conditions could not overcome the steps involved in the metastatic process, might have been transferred and facilitated in producing a new neoplastic colony.

Specific comments.

1. Authors performed pembrolizumab after resection of single omental metastasis. Pathological diagnosis of resected kidney was pT3a clear cell RCC with Fuhrman grade III. Please describe the reason for not doing adjuvant pembrolizumab after radical nephrectomy.

→ Thank you for valuable comments.

Currently, the adjuvant pembrolizumab is not covered by Korean health insurance. So it's very expensive. Immediately after radical nephrectomy, he refused the

adjuvant pembrolizumab due to its high cost, but agreed to use it after second operation.
I added this point to the manuscript.

2. In case presentation session, “Biopsy showed pT3a clear cell RCC with Fuhrman grade III.” Should be revised “Pathological diagnosis of resected specimen was pT3a clear cell RCC with Fuhrman grade III.”
→ Thank you for valuable comments. I revised the sentence.

3. In the Figure 2 and Figure 3, authors should identify the site of omental metastasis by using arrow or arrow head.
→ I've marked the site of omental metastasis with an arrow.