Dear Editor
Thank you for the valuable comments that improve the manuscript, and We do attach the response here in this file.

Regards,

Title: suitable

Response: Not applicable

Abstract: suitable

Response: Not applicable

Key words: If possible, I recommend adding other words such as 'adverse event or postoperative complication' than 'transurethral resection of the prostate'.

Response: Done

Background: Prostate size is usually measured by volume, so I recommend changing g to ml.

Response: Done.

Case presentation:

□ Please mention about the details of patient's prostate. For example, preoperative prostate volume (maybe 54ml, but if so, you should show it in the history of present illness section), with or without middle lobe enlargement and urethral angulation. In addition, please mention about the numbers of WAVE ablation including FOVs (right lobe, left lobe, , respectively). Moreover, please show the result of preoperative urine culture and the details of usage pre- and post- surgical antibiotics.

Response: Done

"…. The patient represented a known case of BPH on medical therapy. He had presented to an outpatient clinic 2 mo prior to this presentation for acute urinary retention with preoperative prostate volume 54 mL with prostatic urethral angulation and no median lobe enlargement. The patient underwent Rezūm™ therapy with water vaporization of both lateral prostatic lobes with three waves for each lobe (9 seconds for each) and two vapor ablations at 5 and 7 O'clock 1 cm from bladder neck. He was given

prophylactic dose of Gentamycin 240 mg intravenous preoperatively. His preoperative urine culture is negative. He did not experience…"

□ Why did the authors select suprapubic catheter after operation? please tell me (not need to mention in the manuscript).

Response: Based on patient preference. In my practice I do keep urethral or suprapubic catheter for 2 to 3 weeks post REZUME and many patients don't prefer urethral catheter. So, based on these I insert SPC that even easy to check post void residual at time of catheter removal to assess patient ability to empty the bladder post REZUM therapy.

□ How does the author decide the duration of catheterization?

Response:

I do keep the catheter for maximum 2 weeks for patients who are not catheter dependent and relatively prostate size less than 75 cc

And in case of larger prostate and catheter dependent I usually keep it 3 weeks

And in my practice some patients request to remove the catheter earlier and try voiding. So, it is variable based upon many factors.

In the current patient the prostate size is relatively small, so I did keep it for 2 weeks.

"…after the procedure for 14 d which is based upon the treating urological practice in the center. The patient experienced successful voiding with no residual urine on day 15 after the procedure.."

□ Please show the antibiotic susceptibility for Klebsiella (only the author showed susceptibility for carbapenems). Please tell me the reason for 2weeks antibiotic therapy with intravenous carbapenems.

Response: **Answered her based upon recommendation. There is no consensus on these rare cases. So, the medical team advise to complete the course as complicated UTI with emphysematous change.**

Based upon the Infectious disease team recommendation is to keep it for 2 weeks intravenous dose because patient has systemic manifestation. And for emphysematous cystitis, the usual standard of care to keep IV Abx for 10 to 14 days as based upon recommendation.

URINE FOR C/S

Pus cell	:	**22-24** HPF
RBCs	:	**0-2** HPF
Gram Stain	:	**GRAM (-VE) ROD**
Organism	:	**KLEBSIELLA SPP. ISOLATED**
Sensitive	:	**MEROPENEM +++** **IMIPENEM +++** **NITROFURANTOIN +**
Resistent	:	**CEFTRIAXONE** **AMOXICILLIN/CLAVULANIC ACID** **CEFIXIME** **CEFOTAXIME** **CIPROFLOXACIN** **GENTAMYCIN** **AMIKACINE** **NORFLOXACIN** **NALIDEX ACID**

□ The author diagnosed the patient was cUTI (febrile UTI), but I want to know the correct diagnosis whether he suffered an acute prostatitis or pyelonephritis or others.
Response: Done Acute bacterial cystitis.

Because *the positive culture for the specimen taken form the catheter in the bladder. So, it is difficult to answer weather prostatitis and complicated to bacterial cystitis or bacterial cystitis alone.*

There was no renal angle tenderness and no flank pain. Also, the imaging study showed no prostatic abscess.

"….
FINAL DIAGNOSIS

Complicated urinary tract infection; acute bacterial cystitis."

□ First, the author selected conservative management, but after 3days, invasive management under anesthesia. Why did the author change the course of action in this case?

Response: Done
Patient travelled to outside country and then he developed this presentation and we did call him to start the IV ertapenem daily till arrival to the treating center.

" …. intravenous ertapenem (1 g) daily in the peripheral primary health care center outside country as an outpatient till he was admitted to the treating center. A urethral catheter was…)

 Please show pre- and post- operative IPSS and IPSS-QOL score (not mention in the manuscript

Response: Done

Preoperatively at presentation was on catheter with retention and failed trial of void 2 times with medical therapy so we did not obtain IPSS score.

The IPS**S post** op after treating this complication is 3 (mild symptoms) and the QoL is 0

"…maximum flow rate of 38 mL/s, voiding time of 39 s, and voided volume of 599 mL (Figure 3). The International Prostate Symptoms Index Score (IPSS) postoperatively is 3 (mild symptoms) with Quality-of-Life QoL from urinary symptoms is equal 0 (Delighted)."