Dear Claire,

Thank you for your E-mail dated 1st March. We accept the reviewers’ and editor’s comments and have amended the manuscript accordingly. We enclose the revised manuscript with highlighted changes. Changes made to the manuscript in response to each comment are detailed below.

On behalf of all authors,
Yours sincerely,

Dr Shaista Hafeez
Editors comments

1. Table 1: Please define the abbreviations used in the table. This can either be done in the first column or in the table legend.

   Agree. Abbreviations defined within table legend p18.

Legend now reads Table 1. A summary of imaging modalities and their current clinical role in staging known muscle invasive bladder cancer. CT computer tomography; US ultrasound; MIBC muscle invasive bladder cancer; MRI magnetic resonance imaging; GI gastro-intestinal; PET positron emission tomography; FDG flurodeoxyglucose.

2. Figure 1: As patient-identifying characteristics are described in the figure legend, it is necessary to obtain consent to publish the images from the patient in question. This information should be contained in the figure legend. If it is not possible to obtain consent, please remove any details about the patient from the figure legend (e.g. patient age and sex)

   Agree. Patient identifiers removed from figure legend p20.

Legend now reads Figure 1. Patient with known T2 N0 M0 bladder cancer (left bladder wall).....

3. Flow chart: As per referee 1’s suggestion, we feel that the minireview will be further improved by the addition of a flow chart describing which procedure to perform in the clinic and when, including the level of evidence.

   Unlike like the investigations performed for the diagnosis of haematuria, staging investigation for confirmed bladder cancer do not follow sequential pathway.

   The nature of the imaging studies also do not easily lend themselves to randomised control studies therefore the level of evidence presented in the paper and supporting current practice is level 2 and 3. Given that the association between evidence and clinical recommendation is not linear, we do not wish to mislead the reader by implying that the absence of high level evidence precludes strong recommendation. We have therefore opted to illustrate the clinical recommendation instead of the level of evidence (which we feel is probably of more relevance to the reader) and reference consensus opinion from the recent European Association Urology Guidelines 2012.

   We have added the figure for your review. See attached.

   Figure 2. Anticipated clinical pathway for staging of confirmed muscle invasive bladder cancer

Reviewer 1
Reviewer: VILLERS Arnauld
Authors responded to all the comments and modified the text accordingly. No further comments

**No action indicated.**

**Reviewer 2**
Reviewer: paolo puppo
The manuscript have been properly corrected. I only suggest to introduce a flow chart describing which procedure to perform and when including the level of evidence in support of each passage. It would improve greatly the impact of the paper to the readers

**See above**