Reviewer’s report

Title: Impact of double J stenting or nephrostomy placement during transurethral resection of bladder tumour on the incidence of metachronous upper urinary tract urothelial cancer

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Reviewer: Shreyas Joshi

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Hupe et al. present a single-institutional retrospective series on the use of upper tract drainage during TURBT and the corresponding incidence of metachronous UTUC. They found the JJ stenting was associated with a higher likelihood of metachronous UTUC than nephrostomy placement, though the overall number that developed this disease was very low. I think it is a useful addition to the literature, in theory, but I do have several comments/questions:

- The average f/u of 12-15 months is a bit short to assess for metachronous UTUC. Furthermore, how many patients had further therapies, such as cystectomy, chemotherapy, or immunotherapy? This would all obviously be important to the survival analysis, but would likely also impact disease occurrence in the upper tract.

- How were synchronous and metachronous defined? Since these were not cystectomy patients, is there a hard "cut-off" period after which new UTUC would be considered metachronous (as was done in the Kiss et al. study - Ref #9). There needs to be a more defined time point or event that will help differentiate synchronous vs. metachronous lesions. Presumably, this would also impact the analysis.

- I was eventually able to find the 3-month cutoff at the bottom of Table 2. Why was 3 months chosen? Did all patients have full upper tract imaging at the time of their initial bladder cancer diagnosis to evaluate for UTUC? If not, you might find some UTUC at follow up imaging that was really synchronous. Were positive upper tract cytologies considered as evidence of UTUC, or just imaging?

- This statement is based off of studies with small cohorts, so I would caution against making a broad statement against a long-considered best-practice procedure (stenting when close to or resecting a UO) without proper studies to evaluate it: "Taken together, the rate of postoperative vesicoureteral obstruction rate during TURBT close to ureteral orifice is acceptably low. Thus, DJ stenting to protect the ureteral orifice might be abdicable."

Are the methods appropriate and well described?
If not, please specify what is required in your comments to the authors.

No

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No

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No

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