COMMENTS FOR THE AUTHOR:

The topic is interesting even if not new. The study suffers of several flaws:

**The three-month follow-up for prostate medication is very limited, especially as some drugs, such as finasteride, show definitive effects after 6 months**.

Thank for this important observation. This study was done as part of student thesis and with lack of registry this is what was possible. As such, we have considered the comment and lowered the study to being descriptive on existing practice with regards to medical therapy in prostate enlargement with symptoms at the hospital. All results addressing after treatment have been deleted.

**Drug treatment is based on the dominant symptoms of patients. Have any patients had any irritative symptoms to take anticholinergic drugs**?

**If this study is prospective study, please include the information of Prospective study` in the title**.

Even though data was collected prospectively, the researcher did not assign treatment hence should be considered retrospective cross-sectional in nature.

**Why do the authors frequently use abbreviation, such as 'MNH' and 'BPE' before complete description?  Similar mistakes should be corrected throughout the manuscript. The general rule is to use an abbreviation for words or phrases that will be repeated more than three times in the text. There for corrected (AUR) and (AE).**

Considered in text

**Wherever the text expresses the mean of a variable, its standard deviation should also be mentioned**.

Considered in text

**Please summarize the introduction section of the manuscript.**

Has been well summarized now.

**According to the guidelines, patients with severe IPSS are candidates for surgical interventions from the outset. What are the authors' logics for including these patients into the study?**

It is true that these patients need surgical management immediately. This reflects on two possibilities of either poor classification or that of not having guidelines. It should be remembered that the authors simply collected data on any patients whose treating urologist prescribed medication for their LUTS. And it should be noted that the score was assigned retrospectively and not prospectively.

**Any efforts to address potential sources of bias are not described.**

Adverse events and symptom score are self-reported by patients hence cannot be regarded as absolute. Rater bias could also exist as well as recall bias as patients might be on other medication that they do not report or remember.

**Please explain how the sample size was determined. Is sample size enough?**

The study being descriptive, did not need sample size estimation to prove any association or significance. Hence the sample obtained was just sufficient and convenient for the study purpose of providing a descriptive picture around the practice in treating BPO patients at Muhimbili National Hospital

**Patient anonymity, consent, and ethical approval number should be mentioned in the manuscript.**

**In results, there are described values that are already in the tables/figure, making reading redundant (merge table 1 by figure 3 data, and deleted figure 2).**

Descriptions of values has been minimized and only statements left. Table one has been deleted and replaced with a pie chart only showing the prescription practice. As the follow up was short to analyze efficacy, that part has been omitted for now. Consequently, Figure 2, table 2 and figure three have been deleted for same reasons.

**Can you please provide some theoretical explanation of the combination therapy inferiority?**

This study was somewhat retrospective in nature. Patients were treated by their treating urologists and the investigators only sought to understand the medical prescription pattern. As you can note, it does not adhere to any known standard treatment guidelines, and choice of one formulation over the other was not based on symptoms nor investigation findings.

**I think it is important to show the limitations of the study in this section**

This was carried out as part of resident thesis hence had shorter duration of follow-up of patients who were on medical therapy. Hence the findings must be interpreted with caution as it was not a clinical trial. A randomised clinical trial is needed in similar settings to define the place of medical therapy in LUTS BPH among African patients and examine related challenges with adherence. This study should therefore be taken as a pilot study investigation the place of medical therapy among BPH patients.

**What is the new findings of this study? What is the strength of this study? Discuss the generalizability (external validity) of the study results.**

This study just found that in spite of LUTS due to BPH being the leading diagnosis at MNH urologist practice, a tertiary treatment facility, no uniform guidelines exists. This has left prescription to be random, and we can speculate that only patients with higher socioeconomic status were put on medical therapy. This study findings will help to raise awareness among practicing urologists on the significance of adapting local protocols and flow charts of selecting suitable candidates for each class of medical therapy. When the situation of practice in a tertiary level is wanting, much or worse should be expected at lower level facilities. We speculate that operative options to address LUTS might be rampant in lower facilities without proper indications and with no medical trial.