Point-by-point response to reviewer’s comments

**Reviewer #1: In this paper, Dr. Paludo et al reported that they encountered increased blood loss and intraoperative complications of tumor rupture during partial nephrectomy. This is of interest to urologists who perform partial nephrectomy. It is necessary to accurately evaluate the number of renal vessels before partial renal surgery, and carefully dissect during the operation to control bleeding and ensure the time of heat ischemia. The author writes fluently and provides intuitive surgical videos. Thanks to the authors for sharing their experiences.**

Answer: Thanks for the comments. We agree that thorough dissection of the renal pedicle is essential for successful partial nephrectomy.

**Reviewer #2 In the current paper the authors provide an interesting case report showing a robot assisted PN complicated by intraoperative bleeding and tumor rupture.**

**The manuscript is well written. The quality of accompanying video material is fine. Also, the idea of presenting a work in which a complication is shown is commendable and has great educational value in my opinion.**

 **I would just address several issues to strengthen the value of clinical message provided.**

**1- This is the case of a nodule in the outer middle third of right kidney measuring 4,5 × 3,5 cm. Authors show that also vein clamp was performed. This may be useful in case of right, predominantly endophytic or hilar renal masses, in which it may be expected a conspicuous venous back bleeding from IVC. In this particular case, clamping of the renal vein without a proper arterial clamping probably led to a higher intraoperative bleeding. I would comment more extensively on such issue in the main document.**

Answer: These comments have been added to the main document: Regarding the clamping of the renal vein during partial nephrectomy, it depends on the surgeon's preference, but most surgeons agree that we need to clamp the vein only during right partial nephrectomy in tumors adjacent to the renal sinus. In this particular case, clamping of the renal vein without a proper arterial clamping probably led to a higher intraoperative bleeding.

**2- I would also focus on tumor resection strategy. Tumor enucleation allows to follow tumor pseudocapsule, following an anatomical resection plane. Keeping always in sight tumor pseudocapsule reduces the risks of violating tumor boundaries, especially if the renal mass is not perfectly round shaped in some parts, as compared to tumor enucleoresection or resection. In the video Authors state that in this case maybe a non-anatomical resection strategy may have protected from tumor rupture. In my opinion tumor rupture was mainly related to a scarce visualization of tumor margins due to an incorrect management of pedicle clamping, rather than due to an incorrect tumor resection strategy. Please comment on this in the discussion.**

Answer: We fully agree with the reviewer's comments, especially that the main error was the incorrect handling of renal pedicle clamping. We believe that most renal tumors have a pseudocapsule, especially clear cell and papillary renal tumors, and it facilitates enucleation, making surgery safer. The fact that the tumor had a large area of necrosis may have facilitated tumor rupture as well.

**- Apart from clamp test, ICG represent a useful and additional tool to tailor pedicle clampling and evaluate kidney ischemia. Of course, in this case it was not available, since the main surgeon was using a da Vinci Si platform. I would discuss it in the proper section.**

Answer: We agree. Add: An additional tool that can be used is Indocyanine green, it is useful to ensure the ischemia of the kidney after clamping the renal artery.

**- What about performing tumor bed biopsy in this case?**

Answer: We agree. Add:Several techniques can be used to resect these tumors, from polar nephrectomy, wide resection, enucleoresection or pure enucleation, which is the standard in most cases. Minervini et all stated that robotic tumor enucleation is safe and achieved negative surgical margins in the vast majority of patients, even in case of complete PC invasion. If after the resection we have any doubts regarding the margins, we can perform a biopsy of the tumor bed. We know that For clinical T1b RCC, tumor infiltration on tumor bed was detected in 6 cases (3.4%), and satellite lesion was detected in 3 (1.7%).