**Request for additional information to guide script writing for your JoVE submission**

In order to facilitate the proper filming of your video, a script writer will prepare both a script and a story board from your protocol prior to filming. For many protocols, steps are straight forward and intuitive, describing actions like mixing solutions, turning on equipment, and so forth. In some instances, however, it is not immediately clear from the protocol itself exactly what the best way would be to represent the action / step in the video. This is especially true for steps describing less common equipment, theoretical processes, image processing or data analysis, and the use of computer programs or software.

When the script writer begins planning your video the protocol will act as a rough guide for the video voiceover. Please consider your protocol in this context and ensure that there are no long sections of text that would be awkward or not-feasible to be incorporated into a voiceover. Please note at this time, if you have not already done so, that text highlighting can be used to indicate to the JoVE staff what you would like to include in the video. Highlighting is used for longer protocols due to length constraints, but can also be useful for protocols of any length if there are sections of introductory or explanatory information that you would like to include in the written protocol but may not need to be included in the video (may be too bulky / time consuming). If you are using highlighting in this way, please use yellow text background and highlight a maximum of 2.75 pages total (including spaces between steps). Please contact your editor with any questions regarding protocol highlighting.

**Generally, there are three types of visuals that can represent a protocol step in your video:** **(1) Videographer footage** (for instance, a lab member performing the action, footage of a process occurring as recorded from videographer’s microscope attachments) ; **(2) screen shots** that display the action or the result of the action (for instance, if you describe setting parameters in software, screenshots can demonstrate the interface; if you describe utilizing a program to perform a step a screen shot of the code can accompany the step); **(3) a schematic or figure** can be displayed to represent the step.

As the goal of JoVE is to visualize methods that cannot be represented optimally in written protocols, we try to avoid having videos with too many screen shots or schematic representations of steps. It is best if actions are filmed live when possible. We understand that many aspects of your work may involve software / programing and the best way to present the protocol may be a combination of both live demonstration and static / animated images. Also please note that an action describing computer / software use should be demonstrated via screen shots, not via videographer footage of a lab member at a computer.

In most cases the determination of the shot list for your video happens later in the JoVE process. However, since there are some steps in your protocol that we are a bit unsure of, we ask that you provide some guidance for us at this time as described below. This way if any changes need to be made to the way the protocol is written or presented, to ensure the best version of your video is made, this can be done prior to peer review. We appreciate you taking the time to provide this information for us and please do not hesitate to contact your editor with any clarifications or questions.

**Please note: this request only applies to certain steps in your protocol as listed in the editorial comments.**

Please fill in the work sheet below, replacing the examples. For each of the steps requested, please designate which of the options would be the optimal representation for visualizing the step (videographer footage, screen shot or figure). If a single step requires two options (for instance part will be filmed in the lab, part will be shown via a screen shot) please separate the step accordingly in the table (not in the protocol). If a figure from the manuscript will be used please refer to it by number and panel letter. If a screen shot will be used, please add the screen shot after the table along with an identifying title. If the screen shot is not currently available a low resolution version or a brief description of it can be used instead. (Screen shots will not be sent to peer review.)

*If edits are made to the protocol later in the review process this guide will not need to be updated unless major changes to the protocol are made.* ***Edits to text segments in this guide will not be reflected in the manuscript.***

**\* Please upload this completed work sheet under the file designation “Supplemental files (as requested by JoVE).\***

**Supplemental information for JoVE scriptwriter**

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| **Step #** | **Text** | **Visual representation** |
| 1 | Sterilely prep the skin and drape the surgical area according to standard of care. | Hand held camera |
| 2 | Perform a standard curved scalp incision for a pterional approach extending from the midline of the scalp behind the hairline with a gentle curve posteriorly and inferiorly towards the tragus ending it about three millimeters anterior to the tragus and at the level of the superior edge of the zygoma. Perform this incision down to the skull above the superior temporal line and to the muscle fascia at the level of the temporalis muscle. | Hand held camera |
| 3 | Use electrocaurtery for scalp hemostasis with the bipolar device . | Hand held camera |
| 4 | Cut the temporalis muscle down to the skull using the bovie monopolar electrocaurtery device. | Hand held camera |
| 5 | Raise a myocutaneous flap keeping the temporalis muscle attached to the undersurface of the scalp for now. Fish-hooks are used to evert the flap after the temporalis muscle is elevated from the skull using a combination of monopolar electrocaurtery and a periosteal elevator. | Hand held camera |
| 6 | Perform an inverse subfascial dissection in the avascular plane from the undersurface of the myocutaneous flap using Metzenbaum scissors, keeping the fascia and subfacsial fat pad with the scalp to avoid injury to the facial nerve. | Hand held camera |
| 7 | Secure the temporalis muscle posteriorly and inferiorly to expose the pterional region with “star” fishhooks | Hand held camera |
| 8 | Keep all components of the myocutaneous flap moist with wetted gauze | Hand held camera |
| 9 | Drill a single temporal 5mm burr-hole at the posterior-most aspect of the planned craniotomy with a 2mm cutting burr so that the foot plate of the side-cutting drill can be inserted into this hole and then use a side-cutting drill with a foot plate to remove the thumb-sized (approximately 3x4cm) kidney-shaped craniotomy centered anteriorly around the pterion. | Hand held camera |
| 10 | Using a No. 1 Penfield, separate the dura on all sides of the pterion and have an assistant gently retract the dura away from the bone surface that is being drilled to minimize risk of penetrating the dura and causing cortical injury. | Hand held camera |
| 11 | Remove the pterion with a drill: anteriorly, until the superior and lateral aspects of the orbital roof are smooth and flattened down to the outer cortical table of bone, without entering the orbit, to maximize subfrontal exposure; medially, drill until the superior orbital fissure dura is exposed and remove any small pieces of bone that would interfere with medial exposure using either a drill bit or hand-held Lempert bone cutting device. Ensure that excellent hemostasis of all soft-tissue and bone surfaces has been obtained to avoid blood dripping into the intradural space during brain dissection and aneurysm exposure, using electrocaurtery and bone wax as needed, before opening the dura. | Hand held camera |
| 12 | Gently elevate the dura and use a No. 11 scalpel to penetrate the dura and then use dural scissors to create a “C-shaped” opening in the dura with the base at the pterion. Secure the dura flat against the outer cortical bone of the orbit without having redundant dural leaflets that would otherwise obscure visualization of the proximal Sylvian Fissure and subfrontal region. This can be performed by using 4-0 Surgilons sutures to tack the dura to the scalp. | Hand held camera |
| 13 | Give 25-50grams of Mannitol at the time of bone flap removal to relax the brain if anesthesia agrees that the blood pressure will tolerate diuresis. | Hand held camera |
| 14 | Keep End-Tidal pCO2 between 30-35mm Hg to achieve slight hypercapnea | Hand held camera |
| 15 | Evacuate cerebrospinal fluid (CSF) to promote brain relaxation by opening the arachnoid cisterns in the interoptic, carotid-optic, and carotid-oculomotor cisterns and patiently suction CSF until the desired brain relaxation has been achieved | Hand held camera |
| 16 | Bring the intra-operative microscope with the mouthpiece into the field using sterile techniques. Also bring surgical chairs with arm support into the field sterilely to maximize bimanual dexterity and to prevent surgeon arm and hand fatigue | Hand held camera |
| 17 | Perform dissection | Video feed |
| 18 | Using bimanual manipulation with surgical microinstruments gently open the arachnoid corridors, holding the brain tissue aside with the edge of the instrument handles or suction device as needed through this exposure. Note: The senior author's preference is to use 4-French Fukishima suction tip in the non-dominant hand and in the dominant hand bipolar bayonettes for blunt dissection or microscissors for sharp dissection. Moistened telfa strips are placed on the brain surface at the site of manipulation to prevent cortical injury | Video feed |
| 19 | Use the mouthpiece on the operating microscope frequently to adjust the scope and focus length as needed while keeping both hands in the field | Video feed |
| 20 | Secure the aneurysm in standard fashion, using the suction most often in the non-dominant hand to maintain the surgical corridor and visualization free of CSF | Video feed |
| 21 | After clip placement, perform intra-operative Doppler and carefully examine the aneurysm neck and parent vessels | Video feed |

**Screen Shots:** (Please copy and paste or insert the required screen shots here, in the order they are listed above.)