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Dear Reviewers,

Thank you for your detailed review and inquiries. Below we include a point by point response to your concerns with referenced changes to the manuscript. All changes have been tracked and any changes addressing your specific concerns have been highlighted in yellow.

***Reviewer #1:   
Manuscript Summary:  
There are many nuances in performing a truly minimally invasive hematoma evacuation with a endoscope. This manuscript has described most of the detail in this procedure, and it is quite suitable for a visualized publication.  
  
Major Concerns:  
Line 133: "3.5.2. Attempt to enter a sulcus if possible."  
Line 141: "4.1.1. If possible, the insertion point should be made within a sulcus to minimize gyral neuronal column injury."  
  
When a sulcus is just right on the burr hole, insert the sheath in a sulcus will increase the bleeding risk. So the sulcus should be avoid except there is enough space for a surgeon to split the arachnid and reach the bottom of the sulcus, which usually you won't have in a 1-1.2cm craniectomy.  
Personally, I prefer to make the cut right beside the sulcus, and insert the sheath along the sulcus and cling the pia.***

Thank you for your review and comments. We have taken them into account and made the following updates.

We acknowledge that a transsulcal approach is often difficult to perform. We have updated the protocol to now read “Given the small size of the 1cm craniectomy, a “trans-sulcal” approach is often not possible and therefore the pia is incised and entered in a non-vascular space immediately below the craniectomy.” (highlighted in yellow)

***Minor Concerns:  
Line 144: "4.2. Remove the introducer and navigation probe once you reach the target point, 1.5cm from the distal end of the hematoma."***

***Sometimes, the clot is fibrous and not easy to be penetrated. If this step is done by force, additional injury can be caused by inexperienced surgeon at the distal part of the hematoma cavity.***

***Therefore, a check point should be added when the tip of the sheath touch the clot surface. If there are some resistance come from the sheath, the surgeon should slightly adjust the penetrating point and find the weak spot, or insert the endoscope to evacuate the blocking clot.***

This concern has been addressed with the following line: “If the clot is particularly fibrous and resistance is encountered, make a slight adjustment to the sheath to reach the target point.” (highlighted in yellow)

***And the safest way should be inserting the transparent sheath with the endoscope placed inside and mounted with navigation system, so that the whole procedure is performed with direct vision.***

Excellent point.

While we prefer to use a navigated probe and find that method safe and effective, we acknowledge many operators prefer to use stereotactic navigation registered to the endoscope rather the sheath introducer for continuous navigation. We have added the following line “Some operators prefer to use stereotactic navigation registered to the endoscope rather the sheath introducer for continuous navigation.” (highlighted in yellow)

***Reviewer #2:  
Manuscript Summary:  
this is an interesting, relevant and well written manuscript  
  
Major Concerns:  
none  
  
Minor Concerns:  
The authors state that there was no increase in ICP or intracavitary pressure during their 2 phase procedure. Is this published yet? Do they have data?  
„5.1.1. We have monitored intracavitary pressure during this phase of the procedure and there is no appreciable intracavitary local pressure increase."***

While we do have data, we have not yet published it and appreciate your point. We have removed this line from the manuscript.

***Why do you think you reduce damage via a transsulcal approach? Is there any evidence or what is the reasoning?***

We agree that while some operators attempt to perform a trans-sulcal approach, there is no evidence that this is beneficial. We have updated the protocol to now read “Given the small size of the 1cm craniectomy, a “trans-sulcal approach is often not possible and therefore the pia is incised and entered in a non-vascular space immediately below the craniectomy.” (highlighted in yellow)

***Reviewer #3:   
Manuscript Summary:  
I have already finish reading this article  
And I highly recommend it***

Thank you for your review and comments.

***Reviewer #4:  
The only items I might suggest adding to the manuscript are a summary of technical challenges for folks learning the procedure and a summary of when this procedure should and should not be used.***

Thank you for your review and comments.

Challenges and the proper way to address them have been included throughout the protocol. In addition, the discussion summarizes important tenets for surgeons to keep in mind when learning and performing the procedure (highlighted in yellow). Also, the inclusion and exclusion criteria for the procedure have now been included to address when this procedure should and should not be used (highlighted in yellow).