

" Far Lateral Lumbar Disc Herniation. Part1: Imaging, Neurophysiology and Clinical Features"

Dear Editor,

We would like to thank you and the reviewers for revising our manuscript. We greatly appreciate the insightful comments provided and we would like to resubmit a new version of the manuscript which addresses the issues raised by the reviewers. We also would like to take this opportunity to respond to the reviewers' comments. We hope that this effort will answer to their questions and the new version of the manuscript will be considered for publication.

Reviewer #1:

We would like to thank you for having read carefully and appreciated our work and for the relevant comments and we hope we have addressed the issues raised.

This is a well written paper. The authors showed that the imaging, neurophysiology, and clinical features of far lateral lumbar disc herniation (FFLH) in detail, I have some comments.

1. The schematic drawing of relationship between dural sac and nerve roots of disc herniations in different axial location should be added.

Response: this have been added in figure 3 A

2.The clinical presentation should be described in more detail, including the area of radicular pain, the special position that result aggravation or mitigation, the natural course of FFLH.

Response: these concepts have been implemented in the manuscript at Page 1 Line 29-33 and Page 2 Line 44-53

3. The classification of FFLH in CT or MRI should be described and the figure of each classification also should be added.

Response: We were unable to find a specific radiological clasification for this type of herni in the literature. however, we have added the radiological features in the text and in Figure 3 B.

Reviewer #2:

On the whole, the manuscript is well written. Some statements and contents need to be modified:

In EPIDEMIOLOGY AND CLINICAL PRESENTATION section :

1. The sentence "FLLDH usually migrate cranially, following the concavity of the dorsolateral aspect of the vertebral body and cause compressive radiculopathy by impinging on the root and dorsal root ganglion from below."is puzzling and should be deleted. Then, the following content is directly connected with the previous paragraph.

Response: this content has been deleted

2. (e.g. in the case of a paramedian L4-L5 herniation, the L4 root) The word "paramedian" in parentheses should be changed to far lateral.

Response: the word has been changed

3. "Foraminal and intra-extraforaminal" should be changed to Introforaminal and extraforaminal.

Response: the word has been changed

In DIAGNOSTIC IMAGING section:

1."cannot not" should delete word "not".

Response: this was corrected

2. word "Hosteophytes" should be osteophytes.

Response: this was corrected

3. Those parameters should be deleted in this paragraph.“A dedicated MR protocol includes sagittal sections, from L1 to S1, T1 spin-echo (slice thickness 3 to 4 mm RT 600 ms, ET 8 ms; FOV 300 x 160 mm) and T2 fast- spinecho (slice thickness 3 to 4 mm RT 3500 ms, ET 100 ms; FOV 300 x 160 mm), T2 weighted fast-spin-echo axial sections (slice thickness 3 to 4 mm RT 4000 ms, ET 120 ms; FOV 200 x 200 mm) parallel to intersomatic discs and T2 weighted fast-spin-echo paracoronal sections from L1 to S1 (slice thickness 4 mm RT 3500 ms, ET 100 ms; FOV 300 x 160 cm)”

Response: this content has been deleted

In NEUROPHYSIOLOGY section: Neuroelectrophysiology is not important in the diagnosis of extreme lateral lumbar disc herniation. This section is a little too much. I suggest refining it.

Response: We agree that neurophysiology is not of enormous importance in this type of pathology but, as it is one of the topics of the article, we have tried to be comprehensive. We have therefore reduced the chapter slightly but have not been able to reduce it very much.

We hope we have effectively addressed the concerns and implemented the suggestions given by the reviewers.

Best regards