Dear Sirs,

On behalf of all authors, we would like to thank you for your comments, that we accepted and revised our manuscript accordingly. Also, please find the answers to questions and comments made by reviewer attached below, highlighted in yellow.

Reviewer(s)' comments and questions with answers from authors:

Reviewer: 1

A well written good conceived manuscript presenting results from an interesting case series report on arthroscopic removal of osteoid osteoma of the knee. Below are point by point comments.

- We would like to thank you for the comment, as we have invested a significant effort in following the patients over the past years and collecting all the data.

Comments

1. I would advise on a statement title rather than question-type title of this paper.

- We have changed the title to: Arthroscopic removal as an effective treatment option for intra-articular osteoid osteoma of the knee

2. The authors started from the hypothesis that the procedure is indeed efficient in removing iaOO for the knee and have not compared the procedure with classical intervention neither with OO in other locations. This is in the same time a limitation of the paper and should be mentioned as such.

- Thank you for your valuable comment. We have added the following text to the manuscript: “Furthermore, we have not compared our results with open surgical

treatment or removal of OO in other locations, as these also represent the limitations of this study. Due to a small number of cases in our study, as well as limited availability of more valued study designs in the literature, we did not find it justified to compare our results with arthroscopic treatment of iaOO in other locations, which have much larger case series. This suggests that only uncommon and novel cases of iaOO of the knee have been published, and further research will additionally clarify peculiarities of this pathology."

3. In the Introduction chapter the reader is informed the aim of the paper is to offer a literature review but then the methods describe collection of a case series report. There is a discordance between this that should be addressed. Please mention in the objective paragraph the intention to report about a case series as well.

- We have clarified this in the revised manuscript and believe no such confusion will occur in this version.

4. Material and methods should read a little more structured (describe in short subchapters the methods for literature review, case series collection, describe the arthroscopic intervention in itself, postoperative management and data interpretation.

- We have revised our manuscript according to your suggestions.

5. Has any quantitative instrument for evaluation of pre /postop knee function/pain used? (VAS, IKDC?)

- Any information regarding knee pain and function was interpreted from the patient's history, but no quantitative instruments for evaluation were used. Postoperatively, success of the surgery was mainly validated by the absence of pain immediately after the surgery.

6. What was the topographical location of the iaOO in author s case series as well as in the literature?

- Topographical locations of the iaOO in our case series and in cases from the literature review was reported in Table 1 and Table 2. However, to highlight the difference between these two, we have added a paragraph concerning this issue to the discussion chapter: "Localization of iaOO in our case series was on the femur exclusively, with 3 cases proximal to the superior cartilage border of the trochlea and one case in the posterior part of the lateral femoral condyle (Table 1). On the contrary, seven cases from the literature report that iaOO was localized on the femoral side, six were on the tibial side, and one was in the patella (Table 2)[1,3,10–20]. However, due to the relatively small number of cases, it is difficult to pinpoint the typical localization of the iaOO in the knee."

7. Were any imagistic follow up performed?

- No follow-up diagnostic imaging was performed. As suggested in the literature, follow-up diagnostic imaging should be performed only in patients with a thorough suspicion of a recurrence of OO. For example, Vanderschueren et al. reported that the most important aspect of follow-up for physicians was clinical assessment after a radiofrequent ablation of OO, while diagnostic imaging wasn't performed frequently. Also, Albisinni et al. state that follow-up diagnostic imaging was unnecessary in patients that had radiofrequent ablation for spinal OO, and were asymptomatic afterwards. Therefore, as our patients were all symptom free during follow-up, we believed no diagnostic imaging is needed. However, we have added this into the manuscript, highlighting it as a possible limitation of the study: "Moreover, a possible limitation to the study is that no follow-up diagnostic imaging was performed. However, it is suggested that follow-up diagnostic imaging should be performed only in patients with a thorough suspicion of a recurrence of OO. Therefore, as our patients were all symptom-free during follow-up, we believed no diagnostic imaging is needed."

References mentioned in the reply:

1. **Vanderschueren GM**, Taminiau AH, Obermann WR, van den Berg-Huysmans AA, Bloem JL, van Erkel AR. The healing pattern of osteoid osteomas on computed tomography and magnetic resonance imaging after thermocoagulation. Skeletal Radiol. 2007;36:813-821 [PMID: 17492439 DOI: 10.1007/s00256-007-0319-1

2. **Albisinni U**, Facchini G, Spinnato P, Gasbarrini A, Bazzocchi A. Spinal osteoid osteoma: efficacy and safety of radiofrequency ablation. Skeletal Radiol. 2017;46:1087-1094 [PMID: 28497160 DOI: 10.1007/s00256-017-2662-1]

8. What was the average dimension of ia OO removed?

- As diagnostic imaging was performed in different institutions over a longer period of time, we did not find appropriate to measure the size of the iaOO due to a possible image quality bias. Intraoperatively, we didn't use exact measurements of dimensions of iaOO removed. However, based on intraoperative findings and orientation using an arthroscopic probe, we believe that all of the removed lesions were smaller than 1,5 cm in any dimension, thus being classified as osteoid osteomas in conjunction with histopathologic findings.

9. Did the author felt, at least in some cases, the need for grafting the articular surface defect?

- Due to the low risk of iatrogenic fracture after excision of the lesions we did not find the need for grafting of the defects.

Best regards,

Mihovil Plečko, MD and associates