

## 2 Peer-review report

Reviewer #1: well-written and described with good outcomes Long head of biceps dislocation fairly common incidence, bilateral rare kindly provide details of the subscapularis tendon intra op.

➔**Thanks for your comment. We accepted your comment and identified intact subscapularis tendon in figure 4. (asterisk)**

also provide details regarding the biceps pulley

➔**Thanks for your comment. We identified fraying of biceps pulley in figure 4 (black arrow)**

also provide the classification Walch , Bennet types

➔**Thanks for your comment. We accept your comment and provided classification (Walch Type 1, Bennett type 4) in final diagnosis section (in manuscript)**

Please state the Lafosse type as well

➔**Thanks for your comment. In our case, however, subscapularis tendons were intact on both sides, making it impossible to classify using Lafosse type**

Regarding the MRI Please add information regarding Chondral print , LHB angle, LHB groove distance -especially as this is bilateral - will add more value. pls add the ref. Long head biceps tendon instability: diagnostic performance of known and new MRI diagnostic signs. Zappia M, Ascione F, Di Pietto F, Fischetti M, Romano AM, Castagna A, Brunese L. Skeletal Radiol. 2021 Sep;50(9):1863-1871.

➔**Thanks for your comment. In our case, LHB angle were both within normal range (Left : 19.5° Right : 16.0°) There were no chondral print found in our case.**

**We included LHB distance (Left : 17.9mm, Right : 20.9mm) in manuscript with additional reference you recommended.**

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Reviewer #2: The paper is well-written, describing clearly and succinctly the anatomy of the area and surgical procedures followed to reduce the bilateral biceps dislocation in this rather unusual case, following the CARE 2016 Statement instructions. The video and photographic material accompanying the manuscript are particularly important in the understanding of the diagnosis of this condition. **However, I would prefer authors to include one more photo (either from the patient or of a graphic representation) of the location of the tenodesis performed.** The follow up times indicated are adequate.

➔**Thanks for your comment. We included one more photo (Figure 5. Postoperative radiograph after subpectoral tenodesis) as you commented. Although we used soft anchor, the location of tenodesis visible in the photo.**