Reviewer #1:

1) the use of US guidance in short axis only for vein puncturing and not for guidewire insertion and proper location as also for dilators and catheter insertion. After the first unsuccessful IJV catheterization the patients should have been followed up for some time clinically and with US for possible complications.

- We used US to guide needle insertion and confirm the guidewire in the IJV after insertion, as shown in Figure 1. Unfortunately, we did not identify the dilator and catheter in the IJV using US after insertion. We assumed that they would be in the proper position as there was no difficulty encountered in dilator and catheter insertion. However, we examined the IJV and surrounding structures above the clavicle before the second insertion but did not detect any problems, such as hematoma. Moreover, there was no hemodynamic change observed, and therefore, we proceeded with the second insertion. (page 5)

2) the surgical procedure was carried on for 3 hours despite the hypotension and need for norepinephrine without any attempt to diagnose the cause. An US examination or xRay should have been performed during surgery. Suggestions for authors 1) the authors should describe more in details the medical judgment for continuing the surgery despite the occurence of hypotension

- Hemodynamic instability did not occur immediately after IJV catheterization. The first hemodynamic change developed when the patient was positioned in the right lateral decubitus position for surgery, and hypotension was treated with fluid replacement. Moreover, there was no obvious abnormality in ABGA and chest auscultation. Accordingly, we proceeded with surgery without the impression of hemothorax because various factors can cause transient hypotension during anesthesia. However, we should have performed chest radiography or US lung scan before proceeding with surgery because negative blood aspiration form inserted catheter at the first attempt was suggestive of inappropriate catheter location.

The second hypotension event developed and sustained after the start of surgery.

During the operation, the patient was in the right lateral decubitus position and covered with surgical drapes and laparoscopic instruments, creating difficulties in right lung examination with ultrasound or chest radiography. Fortunately, we maintained hemodynamic stability with fluid and norepinephrine infusion and planned to evaluate the patient after surgery to identify the cause. We have included this content in the Discussion (page 7, 8) and Conclusion section of the manuscript.

Reviewer #2: The reviewer cannot recognize any clinical point. The reviewer also does not find out any educational value in the images.

- Life-threatening hemothorax develops in most cases due to intrathoracic vascular injury during central venous catheterization. However, routine US guidance observing only IJV cannot guide intrathoracic advancement of guidewire or catheter. Therefore, we recommend that the guidewire position in the brachiocephalic vein should be confirmed using US to decrease the risk of intrathoracic vessel injury.

Furthermore, this case showed that the hemothorax caused by intrathoracic venous injury could not be associated with immediate hemodynamic instability. Hypotension induced by venous bleeding can develop after a time lag and be manageable with fluid and vasopressor therapy during general anesthesia, as in our patient. During anesthesia and surgery, many factors causing hypotension can obscure prompt diagnosis, and diagnostic equipment such as chest radiography or lung ultrasound scan cannot be applied immediately, according to the surgical position and technique. Therefore, clinical suspicion and timely diagnostic evaluation are needed for early diagnosis. Our case also showed that intrathoracic venous injury during IJV catheterization was self-controlled without any surgical repair or compression. We added these contents in the Core tip and Conclusion.