

The authors have created a new tool that will be useful in determining the optimal treatment path for pediatric patients with foot problems. It is an innovative questionnaire that will improve the diagnosis process. The aim of the work was clearly defined, the methodology of the procedure was properly planned and implemented. Adequate statistical analysis tools were used.

Thanks for the positive comments. The authors believed that the reviewer contribution was helpful to improve the manuscript quality.

Q1. The authors should definitely explain who the questionnaire is intended for. The title does not indicate for which patients (children or adults) this tool was created. In the summary, in the conclusions it was written that for children. However, in the conclusions at the end of the discussion it was written that for juvenile flexible flatfoot.

A1) As you suggested the title was partially rewritten

Q2. The questionnaire sheet shows that the respondents can be from 0 years old to more than 14 years old (no upper age limit has been set). Isn't it a limitation of the assessment of the questionnaire that the condition of inclusion in the study was "chronological age 17-years-old"? The study group was very homogeneous in terms of age, in this case this may be a disadvantage.

A2) Thanks for your comment. As reported in the inclusion criteria, patients until skeletal maturation were included in the sample. EPOS and SITOP members did not support the surgical indication in more than 14 years old patients, for this reason, no points were set for more than 14 years old. The authors do not believe that could be a limit to the score assessment

Q3. Please also clearly emphasize that the proper assessment and indication for surgery also requires (in addition to the features resulting from the questionnaire) the assessment of the entire body posture (for example, comparing the length of the limbs) and a detailed history of diseases, family history, etc. The tool proposed by the authors will be a very good help, but care should be taken when making a final diagnosis.

A3) Thanks for your comment. The CTF aim is not to replace the clinical assessment or the physician evaluation but to offer to young and no pediatric orthopedic surgeons a common accepted and objective additional tool for the correct flatfoot grade and surgical indication. The phrase was added in the discussion section

Reviewer #2: Pleased to review a nicely written article dwelling on a pertinent issue. Authors deserve applause for the effort. However, there are some minor concerns that need to be addressed.

Thanks for the positive comments. The authors believed that the reviewer contribution was helpful to improve the manuscript quality.

Q1) Title: I believe, it could have been more inclusive; can add " for Child" in the title.

A1) A1) As you suggested the title was partially rewritten

Q2. "Introduction" should elaborate with previously published tool/scale for the FFF and their merits and demerits for formation of your research problem.

A2) Unfortunately, the CTF score is the first specific assessment tool for the FFF, the authors believe that the other no specific questionnaire inclusion could be misleading for the reader

Q3. In the subsection 2.1.1, citation is missing for development of CTF.(second sentence of para 1).

A3) The CTF Score development was composed of two part, the CTF Score Conception and CTF Score Composition and Scoring.

Q4. Full form of VP, GT, AV. In the sub-section 2.1.2, 80 is the scoring of current subjects or is it scoring of questionnaire minimum score. Although, in the questionnaire each domain has zero value, then how is it minimum 80. Same 170. Elaborate with justification. 250 in the formula. Why 250? Elaborate with justification.

A4) the full form of the authors name was included in the text. The authors are sorry for the typo. The minimum score is -80, while the maximum is 170. An easier percentage conversion justifies the 250 values. At present, a single CTF domain value is not provided, the authors believe that each domains participated to the proper clinical assessment, splint off the domains could generate a bias.

Q5. How the patient with Flexible flat foot is segregate from rigid flat foot. Explain in the sub-section 2.2.

A5) the clinical testes for the flexible flatfoot assessment were added in the inclusion criteria

Q6. Define the none, mild, and severe for each domain. Similar for Yes and No.

A6) Thank you for the comment. As for each score, some criteria are related to the examiner experience. In order to provide an easy-to-use tool, more specific criteria were not set for the valgus of the hindfoot, longitudinal arch, forefoot abduction, and triceps contracture assessment and the evaluation is delegated to the observer. The comment was included in the limits of the study

Q7. Result section, there should be the summarized result (table) of each domine of scale for better understanding.

A7) As previuos reported, the authors believe that each domains participated to the proper clinical assessment, splint off the domains could generate a bias.

Q8. Content of the Figure 2 and 3 should be visible. Improve the quality.

A8 The quality was improved

Q9. Discuss about result and interpretation in subsection 3.3.

A9) subsection 3.3 was interpreted in the discussion. As reported the 75% CTF score cut-off presented high sensitivity and specificity as reasonable cut-offs for surgical treatment. The administration of the questionnaire to a larger sample and less specifically trained observers could modify the cut-off

Q10. What are the future directions of this topic described in discussion section?

Q10) As reported in the discussion, the administration of the questionnaire to a larger sample and less specifically trained observers, reassessing test-retest reliability, and the development of a digital application are the future features of the score