1. Please, indicate what kinds of disposable biopsy devices were used.

We used Bard Max-Core disposable core biopsy instrument with 18-gauge needles.

2. As the authors pointed out, Coagulation tests were performed a day before the biopsy, and if required, they were corrected using fresh frozen plasma or vitamin K to normalize the results. How many patients had these treatments prior to the biopsy? Why weren't they evaluated as predictors?

Out of the 255 kidney biopsies performed, only 5 patients exhibited minor abnormalities in their coagulation tests prior to the procedure. This 2% incidence was deemed statistically insignificant. Importantly, none of these 5 patients experienced any bleeding complications post-biopsy. Consequently, our team decided not to incorporate coagulation tests as predictive factors. Moreover, it is worth noting that the occurrence of post-biopsy bleeding could not be linked to abnormal coagulation test results, as all patients involved in this study displayed normal coagulation results or had their abnormalities corrected before the biopsy.

3. It can be assumed that the risk of bleeding depends on the nature of kidney disease. Why authors analyze only clinical syndromes related to renal disease but don’t take into account specific diagnosis, verified by the biopsy?

We agree with the reviewer's assumption that the risk of bleeding depends on the nature of kidney disease. However, previous research has also demonstrated that certain clinical syndromes, such as acute kidney injury, can increase the risk of post-kidney biopsy bleeding. We have analyzed clinical syndromes in our study in an attempt to find any such association in our patients. In our current analysis, we have not yet delved into the specifics of each kidney biopsy histopathology report to extract precise diagnoses.

Instead, we utilized information related to the clinical syndromes that prompted the need for kidney biopsy as part of our analysis. In the future, once we have thoroughly examined the details within each kidney biopsy histopathology report, we intend to incorporate this data into our subsequent studies.

4. How was the number of passes chosen? What was the difference between patients from whom samples 3 and 4 were taken? Could there be any confounders associated with this risk factor?

The majority of patients (92.4%) required two passes during the procedure, with only 11 patients (5.6%) needing three passes and 3 patients (1.5%) requiring four passes. The decision on the number of passes was made by the procedurist based on whether sufficient core samples were obtained. It's worth noting that unlike some other institutions where nephrologists might determine the number of passes based on factors like the suspected kidney disease or the need for adequate representation of vessels, our institution did not follow this practice. Potential variables that could have influenced the number of passes included the patient's weight and kidney size. In a post-hoc analysis, we compared patients who had three passes with those who had four passes. Among those with three passes, the mean body weight was 69.6kg, and the mean kidney size was 10.8cm. Among those with four passes, the mean body weight was 61kg, and the mean kidney size was 10.4cm. Importantly, there was no statistically significant difference between these two groups. Additionally, it's worth noting that these potential confounding factors were adjusted for through the multivariate analysis utilized in our study.