

## ANSWERING REVIEWERS



June 1, 2013

Dear Editor,

Please find enclosed the edited manuscript in Word format (file name: 2498-review.doc).

**Title:** Burr-hole evacuation for infratentorial subdural empyema.

**Author:** R Alimehmeti, A Seferi, G Stroni, S Sallavaci, A Rroji, K Pilika, M Petrela

**Name of Journal:** *World Journal of Clinical Cases*

**ESPS Manuscript NO:** 2429

The manuscript has been improved according to the suggestions of reviewers:

1 Format has been updated

2 Revision has been made according to the suggestions of the reviewer

(1) No image of first brain CT is presented...It was not mentioned whether right mastoid cells opacity was observed in it. Answer: CT scan in 2006 was not easily available in our center. There was not image archive and printing was not available at any time and it was mostly done in case of positive findings. We possess only the clinical record file with the written comment of the radiologist that there was no mass effect and no comment of mastoiditis was there.

(2) The lab data of the first day of admission and 10 days later would be better to be put into a table. Answer: A table is created to collect lab data and included in the revised manuscript.

(3) The way of managing hydrocephalus was so risky given that neither craniectomy nor ventricular drainage had been performed. In such a comatose patient with acute hydrocephalus - which is obvious in brain CT- it was wise to have a temporary CSF withdrawal system and taper it gradually, in particular when decompressive craniectomy had not been performed. Answer: We completely agree with the reviewer that hydrocephalus was important component of intracranial hypertension and needed treatment. In emergency conditions with a CT appearance of no conspicuous cerebellar edema we started with evacuating empyema. The first burr-hole was aimed and done in the center of empyema with the intent to continue with craniectomy in case evacuation from the first burr-hole was not possible for the pus viscosity. At the first attempt we could withdraw the quantity of pus that corresponded to the whole pus calculated to the preoperative CT. The opening of dura under burr-hole revealed cerebellum that had regained posterior fossa wall. In lack of cerebellar edema, confident that the removal of empyema and mostly considering the patient quick progressive recovery from comatose state made us think that CSF dynamics had been re-established at the posterior fossa. The clinical situation further improved consecutively reinforcing that hydrocephalus was resolving. The postoperative CT confirmed it. External ventricular drainage was not necessary after all.

(4) The discussion and conclusion parts should give enough rationale for the authors' claim that their technique can be adapted as "first line" approach. It was better to say that it can be accepted as an "alternative" to other more invasive surgical approaches in certain situations. Answer: We corrected accordingly that it should not be used as first line approach but can be accepted as an alternative to other more invasive surgical approaches in certain situations.

(5) The grammar and syntax in this submission are suboptimal. The manuscript was linguistically revised by native English at this review.

(6) LP - lumbar punction should be changed to lumbar puncture. Answer: It is replaced as suggested.

(7) describe in detail what GCS 12 or 5 was - ie. the E?V?M?. Answer: It is described as suggested.

3 References and typesetting were corrected

4. English language revision was done by a native English speaker.

Thank you again for publishing our manuscript in the *World Journal of Clinical Cases*.

Sincerely yours,

Ridvan Alimehmeti MD PhD

Service of Neurosurgery

University Hospital Center “Mother Theresa”

370 Dibra Street

Tirana, Albania

Telefax: 00355 42362641.

Telephone: 00 355 692102140

Email: [ridvanalimehmeti@hotmail.com](mailto:ridvanalimehmeti@hotmail.com)