

Dear Sir or Madam,

Thank you very much for your review and the comments, which were very valuable to us for the revision. We have fully revised the text and indicated the issues we addressed with red font in the body of the article. Please find more detailed answers to your questions below. These answers were also incorporated in the manuscript, labelled in red. We hope that the revisions are satisfactory.

Reviewer 1

QUESTION 1. Dear editor and authors, I am pleased to note that informed consent has been given by the patient for this report to be written. However, the patient is a 9-year-old patient with a brain lesion. Written consent from the guardians or parents may be more preferable for this particular case.

ANSWER 1. The consent was introduced to the family and to the patient in the course of the outpatient visit and during the in-hospital preparation to the operation and the patient has given the consent for publication. However, since the patient was a minor, his parents have signed the document.

QUESTION 2. In INTRODUCTION, fourth paragraph: “Classically, the obstruction of CSF flow within the ventricles is classified as obstructive (non-communicating) hydrocephalus, whereas the obstruction of CSF flow or its absorption in the subarachnoid spaces is known as communicating hydrocephalus.” Please revise this sentence with the definition of both types of hydrocephalus with references for clarification.

ANSWER 2. Classically, the obstruction of CSF flow within the ventricles is classified as obstructive or non-communicating hydrocephalus, whereas the obstruction of CSF flow or its absorption in the subarachnoid spaces is known as communicating hydrocephalus. The obstructive hydrocephalus, as the name implies, is defined as an obstruction of the CSF flow, while the communicating hydrocephalus occurs when full communication between the ventricles and subarachnoid space is present. Here, the main causes include defective

absorption, overproduction of the CSF or venous drainage insufficiency. In the acute form of obstructive hydrocephalus, especially in young patients, only minor ventriculomegaly may be present in spite of a significant rise in the intracranial pressure. With long standing CSF pressure on the brain parenchyma, the ventricular system dilates, compressing and thinning the overlying cortex.

This part has been added into the manuscript.

QUESTION 3. The cause of hydrocephalus in your case is obstructive. At what point is the block to cause hydrocephalus per se? Is the fourth ventricle dilated? Illustrative Figure 1 sagittal view demonstrating the site of obstruction would be worthwhile. Please label the figures with arrows to show the readers.

ANSWER 3. Thank you for this remark. The cause of hydrocephalus is obstructive with the blockade of the CSF flow at the level of the aqueduct because of a tumour in the right part of the tectum. The fourth ventricle is normal and the supratentorial ventricular spaces are dilated, which is clearly seen on the sagittal view of the T2 phase of the MRI (Figure 1a). This description has also been given in the figure section, Figure 1. The stenosis causing the obstruction in the aqueduct has been labelled in the Figure 1 in order to help the reader.

QUESTION 4. Are there any CSF flow studies demonstrating abnormal hyperdynamic CSF motion in your case? Are there signs of meningeal infiltration of the tumor? Are CSF studies available to document possible high protein content due to tumor? This “elevated CSF protein” may be problematic with a shunt. The authors should emphasize on the appropriate diagnostic work-up in the patient.

ANSWER 4. Our patient did not have signs of hyperdynamic CSF circulation on the MRI. At the level of stenosis, the flow void can be seen on the MRI when the CSF flow is enhanced through the narrowing. In our case, no flow was discernible at the level of the aqueduct, suggesting a complete flow blockade by the tumour. The lumbar puncture was not performed in advance as it is contraindicated due to the risk of possible herniation after the CSF removal and consequent neurological deterioration.

On the MRI, no signs of meningeal infiltration by the tumour were noted. For possible pathohistological diagnosis, the CSF samples were taken, which were normal. The CSF was taken during the endoscopy, just when reaching the ventricles. Routine microbiological, cytological and biochemical analysis were performed and the constituents were within the normal limits (with no elevated protein content and no tumour cells present).

Shunt placement is an option to the ETV in such patients, although sometimes problematic, especially in patients with a high protein content of the CSF, which may cause the shunt (valve) obstruction. In our patient, the CSF was normal in the composition and devoid of tumour cells. In case of an ETV failure, shunt would present a sensible treatment option.

The diagnostic workup has been added into the Case presentation section and discussed in the Discussion.

QUESTION 5. Additionally, please further proof-read the paper. There are spelling and grammatical errors throughout the text. These are minor, but should be corrected by the authors. In INTRODUCTION, first paragraph: Dady Walker syndrome... In INTRODUCTION, first paragraph: ...age-dependant. In INTRODUCTION, eighth paragraph: ...CSF from third ventricle into the interpenducular cistern and... In CASE PRESENTATION, second paragraph: ...which was highly suspectful for tectal low grade astrocitoma. In CASE PRESENTATION, third paragraph: ...foramen Monroe... CONSLUSIONS

ANSWER 5. Thank you for this remark. The text has been corrected and proofread.