

## Diagnosis, treatment, and complications of radial head and neck fractures in the paediatric patient.

Thank you for your review of our manuscript. Please find below each comment accompanied by a response and the changes that are made to the manuscript.

Reviewer's comments:

Comment:	Response:	Changes:
<p>For the authors This study is a review article that overviews the diagnosis, treatment and complications of Radial Head and Neck Fractures in the Paediatric Patient. In this manuscript, there are some points that need to correct and improve.</p> <ul style="list-style-type: none"> <li>• Are there any signs or clues that suggest the concomitant injury</li> </ul>	<p>This point is addressed in the subheading 'concomitant injury' (p. 3-4). However, the available data is limited. We have added one more risk factor: younger age. (see p. 3-4).</p>	<p>Line 90: Risk factors for concomitant fractures include joint effusion, young children, and complete or displaced proximal radius fractures.[5,7] Line 96: Therefore, when assessing a child with a suspected fracture of the proximal radius, thorough examination of the wrist, shoulder and contralateral arm should be performed to exclude associated injuries.</p>
<ul style="list-style-type: none"> <li>• As we know, the ligamentous injury is rare. Which cases are suitable for evaluating with MRI?</li> </ul>	<p>This is a very valid question, but there is limited data. We have added our recommendation based on the available evidence.</p>	<p>Line 118: In addition, magnetic resonance imaging may be useful in assessment of ligamentous integrity in case of elbow instability, dislocation, or secondary instability after successful treatment of the fracture.[2,19]</p>
<ul style="list-style-type: none"> <li>• Please show the success rate in each close reduction technique.</li> </ul>	<p>This is a good point. Unfortunately, we were unable to find the success rates for each technique separately. In the literature, the technique for closed reduction is often not reported. Instead, we've added the overall success rate of closed reduction.</p>	<p>Line 183: Overall success rate of closed reduction is approximately 25%, with higher success rates in lower Judet grade fractures.[33]</p>
<ul style="list-style-type: none"> <li>• How does the surgeon avoid or decrease the incidence of radio-ulnar synostosis.</li> </ul>	<p>The incidence of radioulnar synostosis is very low, therefore there is very limited evidence for any preventive techniques. We have added practical recommendations.</p>	<p>Line 281: Radio-ulnar synostosis is associated with open treatment of proximal radius fractures. Therefore, the incidence of synostosis is most effectively reduced by using minimally invasive techniques when possible.[3,26,41] Furthermore, it is the senior</p>

		authors' practice to remove bone dust using gel or water and avoid interfering with the radio-ulnar space.
first: This is not novel topic, but the authors have added the recent evidence on radial head fracture in this review.	Thank you	none
second: It is clear for the type of review article. It is easy to be followed.	Thank you	none
Third: It would be great if the authors could suggest the research trend in this topic or point out controversy issues in the last section.	Thank you for this excellent suggestion. Please see the last part of the paper for the additional text.	Line 400: There is controversy in the literature regarding the treatment of older paediatric patients nearing skeletal maturity and whether they should be approached in a similar fashion as adult patients. Furthermore, apart from striving to use the least invasive treatment options, there is limited data available on prevention of specific complications. In addition, the rate of missed fractures and missed concomitant injuries is relatively high. Future research should focus on more accurate diagnosis, expanding the closed and percutaneous treatment options, and prevention of complications.
Issues raised: (1) The "Author Contributions" section is missing. Please provide the author contributions	Our apologies.	Author contributions were added.
(2) The authors did not provide original pictures. Please provide the original figure documents. Please prepare and arrange the figures using PowerPoint to ensure that all graphs or arrows or text portions can be reprocessed by the editor;	Of course.	We've also added arrows pointing to the fat pad signs in Figure 1.
Before final acceptance, uniform presentation should be used for figures showing the same or similar contents; for example, "Figure 1Pathological changes of	Of course.	Figure numbers are adjusted.

atrophic gastritis after treatment. A: ...; B: ...; C: ...; D: ...; E: ...; F: ...; G: ...".		
	We have made a few additional changes for language editing and fine-tuning.	Line 31: rotational impairment, Line 58: indicating the appropriate treatment Line 75: limited range of motion Line 89: as part of a Line 125 and 138: the choice of treatment Line 157: an isolated Line 395: type of treatment