30 April 2023
Dear Editor,

Re: manuscript reference no. 85242

Thank you for sending the referees’ comments on our manuscript entitled: Hourglass-like constriction of the anterior interosseous nerve in the left forearm: a case report and review of the literature over the last 10 years. The authors would like to thank the reviewers for providing feedback on this manuscript, which was both positive and constructive. We have integrated these comments and suggestions into our revised manuscript, highlighting the edits through track changes. We have also separately summarized the reviewers’ feedback and listed our responses as enclosed here for your reference.

I hope you find the revised manuscript satisfactory and acceptable. Should you have any further questions or comments, please do not hesitate to contact us.

Yours sincerely,
Yu Zhou (on behalf of all authors)

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Response to the ID: 05504262 Reviewers’ Comments

1) Abstract: a. The abstract should provide a brief summary of the main findings and conclusions of the case report. The current abstract can be improved by including a clear statement of what the case report is about, what the authors found, and what the implications are for clinical practice. b. The abstract should not include the keywords; they should be listed separately after the abstract.

Response: Thank you for the comments. Modifications have been made as required.

“Background: Hourglass-like constriction neuropathy is a rare neurological disorder. The main clinical manifestation is peripheral nerve
injury with no apparent cause, and the pathomorphological change is an unexplained narrowing of the diseased nerve. The diagnosis and treatment of the disease are challenging and there is no accepted diagnostic or therapeutic approach.

Case summary: This report describes a rare hourglass constriction of the anterior interosseous nerve in the left forearm in a 47-year-old healthy male who was treated surgically and gradually recovered function over a 6-month follow-up period.

Conclusion: Hourglass-like constriction neuropathy is a rare disorder. With the development of medical technology, more examinations are now available for diagnosis. This case aims to highlight the rare manifestations of Hourglass-like constriction neuropathy and provides a reference for enriching the clinical diagnosis and treatment experience.”

2) Introduction: a. The introduction can be made more concise by focusing on the purpose of the study and the gap in knowledge that it addresses. b. The current introduction is too detailed and includes information that is not relevant to the study. In the introduction, the phrase "one or more nerve trunks (nerve branches)" is redundant, as a nerve trunk is a bundle of nerve fibers or axons that run together in the peripheral nervous system. c. The phrase "but they are different" at the end of the third paragraph of the introduction is unclear and does not provide enough information. It should be revised to provide more clarity.

Response: Thank you for the comments. Modifications have been made as required. We have highlighted in red the parts of the original Introduction section that have been modified.

“Hourglass-like constriction neuropathy is a complex neurological disorder, the cause is unknown, but is typically characterised by hourglass constriction of nerve trunks (nerve branches). The clinical features are characterised by sudden onset of pain followed by dysfunction of the motor or
sensory functions innervated by the corresponding nerve[1–3]. Hourglass-like constriction neuropathy has not been studied separately for its epidemiology as most scholars consider it to be the result of an altered structural pathology[4].

The preoperative diagnosis of this disease is challenging, and the definitive diagnosis is usually made after surgical exploration. Ultrasound and Magnetic resonance neurography (MRN) are useful in diagnosing nerve hourglass constriction, but are usually not visualised by conventional magnetic resonance imaging (MRI) [5]. Due to the rarity of the disease and the limitations of the investigations, in general, many physicians will often misdiagnose it as neuritis or some localised nerve entrapment syndrome based on its signs and symptoms, but they are different. The latter is often misdiagnosed because their symptoms are particularly similar, mostly due to aseptic inflammation or viral infection and mechanical compression, whereas the former is more often a neurological organic lesion. On the other hand, the treatment of these diseases can be very challenging and although there are many surgical options, such as epineurectomy and neurolysis, resection and neurorrhaphy or nerve grafting, the results are not satisfactory [6,7].

We report here a case of hourglass-like constriction of the anterior interosseous nerve in the left forearm, which recovered after surgical treatment. In addition to this, we have retrospectively analysed cases that have been reported as hourglass-like constriction treatments in the last decade to analyse their efficacy.”

3) Case presentation: a. The current case presentation is well-written and includes all the necessary information. b. However, the physical examination and DR examination results can be presented more clearly. Consider using tables or bullet points to highlight the key findings. In the case presentation section, the phrase "Nil of note in his medical history" is not a common medical phrase and could be rephrased to "No significant medical history". In the physical examination section, the phrase "emptier than that of the right wrist"
should be "flatter than that of the right wrist." c. The phrase "DR examination" should be revised to "Digital radiography examination" to clarify the acronym.

Response: Thank you for the comments. Modifications have been made as required. We have highlighted in red the parts of the original Case presentation section that have been modified. On the other hand, we believe that the full range of typical anomalous signs has been described and that the DR examination is not significantly abnormal, with no skeletal defects or anomalous positional changes, so we feel that this section is complete.

"Chief complaint: The patient, a 47-year-old male piano tuner, complained of weakness in his left hand, with no apparent traumatic cause of flexion or extension of the distal phalanges of his left thumb for two months.

History of present illness: The patient has no family history of alcohol or tobacco addiction and was in good overall mental condition.

Personal and family history: No significant medical history.

Physical examination:

Left thumb long flexor tendon strength grade 4, left index finger deep flexor tendon strength grade 0, left thumb short flexor strength grade 5, left index finger short flexor strength grade 5, no significant abnormalities of superficial skin sensation in the left hand and left forearm. The palmar aspect of the left wrist is flatter than that of the right wrist (anterior rotator muscle), and there are no significant abnormalities in finger movement or blood flow in the remaining fingers.

Digital radiography examination:

The left ulnar radius is regular in shape with continuous bone cortex and clear bone trabeculae, with no obvious signs of bone destruction. The distal
ulnar flexor and flexor carpal joint gaps were moderate and there were no obvious abnormalities in the surrounding soft tissues (Figure 1).

Colour Doppler examination:

Widening of the median nerve cross-section over the left elbow, left side wide (0.48 cm × 0.29 cm,) hypoechoic, star grid-like changes, the left side of the median nerve at the elbow is about 0.54 cm × 0.29 cm wide (right side is about 0.52 cm × 0.27 cm wide) locally hypoechoic, local nerve bundle thickness varies, one obvious narrowing is visible, local nerve bundle width is about 0.08 cm, proximal segment is 0.17 cm, the distal segment is 0.14 cm. The body surface was marked and the median nerve at the wrist was approximately 0.62 cm × 0.23 cm wide on the left (0.76 cm × 0.38 cm wide on the right).”

4) Diagnosis: a. The diagnosis section needs to be revised to include a clear statement of the diagnosis and how it was reached. b. The current diagnosis section is unclear and does not provide a definitive answer. In the diagnosis section, there is a question mark after "Anterior interosseous nerve injury of the left forearm." This should be removed as it is not necessary and makes the diagnosis unclear.

Response: Thank you for the comments. Modifications have been made as required. Based on our surgical exploration of the visual exposure, we gave a straightforward final diagnosis: Hourglass-like constriction of the anterior interosseous nerve in the left forearm.

5) Treatment: a. The treatment section needs to be revised to include a clear description of the surgical procedure and the outcome. b. The current treatment section is too brief and does not provide enough information on the surgical approach or the patient’s recovery. c. In the treatment section, the phrase "the biceps tendon membrane was exposed" should be "the biceps tendon sheath was exposed."
Response: Thank you for the comments. Modifications have been made as required and highlighted in red.

6) Discussion: a. The discussion should focus on the implications of the case report for clinical practice and the current understanding of hourglass-like constriction neuropathy. b. The current discussion is too brief and does not provide a comprehensive analysis of the findings.

Response: Thank you for the comments. Modifications have been made as required and highlighted in red.

“The surgical treatment was carried out by microsurgeons. The patient was placed in a supine position, prepared routinely for surgery, and a tourniquet was applied. Based on the previous colour doppler examination, a longitudinal incision of approximately 10 cm was made on the proximal palmar side of the left forearm as the surgical incision approach. The skin and subcutaneous skin were incised in accordance with the procedure and the biceps tendon sheath was exposed and incised. The main trunk of the median nerve was surgically exposed between the pronator teres and the radial carpal flexor, dissected along it to the anterior interosseous nerve, and the pronator teres were drawn radially to reveal the superficial flexor fibre arch. The interosseous anterior nerve was then loosened to free the epineurium. The continuous research for the lesion location, and around 1cm after the anterior interosseous nerve, it separates from the trunk of the median nerve. An incomplete dissection of the interosseous anterior nerve was seen at approximately 1 cm from the main branch of the median nerve, the epineurium was continuous, and the nerve bundle (axon removed) was almost completely dissected, with the connection accounting for approximately 20% of the total diameter and scarring degeneration at the dissection site. Approximately 3 mm of diseased tissue is excised from the neuropathy site and the nerve repair anastomosis is then performed (Figure 2). After flushing the incision site and stopped the bleeding, the nerve anastomosis is wrapped with collagen sponge and the surgical
incision is closed layer by layer. External fixation in plaster was performed. We advised the patient to try to start functional exercises for the distal fingers, such as forceful fist clenching, as soon as the pain and swelling had subsided three days after surgery. Two months after the operation, the cast was removed, and the functional exercise of the affected limb was further strengthened. At 6 months postoperative follow-up, there were significant improvements in symptoms and return of voluntary movement."

7) References: a. The references need to be formatted correctly according to the journal guidelines. b. The current references are not in the correct format and are incomplete.

Response: Thank you for the comments. Modifications have been made as required.

Response to the ID: 06109990 Reviewers’ Comments

1) Editing and English language corrections are necessary. I highlight some of them in yellow color.

Response: Thank you for the comment. As we used British English, which may have caused the reviewers to misunderstand, our native speaker reviewed it again and revised it as well.

2) The title exceeds the upper limit allowed by the journal (18 words, therefore I suggest the following title "Hourglass-like constriction of the anterior interosseous nerve in the left forearm: A case report and literature review"

Response: Thank you for the suggestion. Modifications have been made as required.
3) Three questions in the Abstract section: aim, conclusion and Core Tip.

Response: Thank you for the comments. Modifications have been made as required. We have made additions and modifications in the Abstract section of the original text, highlighted in red.

“Background: Hourglass-like constriction neuropathy is a rare neurological disorder. The main clinical manifestation is peripheral nerve injury with no apparent cause, and the pathomorphological change is an unexplained narrowing of the diseased nerve. The diagnosis and treatment of the disease are challenging and there is no accepted diagnostic or therapeutic approach.

Case summary: This report describes a rare hourglass constriction of the anterior interosseous nerve in the left forearm in a 47-year-old healthy male who was treated surgically and gradually recovered function over a 6-month follow-up period.

Conclusion: Hourglass-like constriction neuropathy is a rare disorder. With the development of medical technology, more examinations are now available for diagnosis. This case aims to highlight the rare manifestations of Hourglass-like constriction neuropathy and provides a reference for enriching the clinical diagnosis and treatment experience.

Keywords: Hourglass-like constriction neuropathy; Anterior interosseous nerve of the forearm; Nerve; Surgery; Literature Review; Case report

Core Tip:

The main aim of this article is to report a case of Hourglass-like constriction of the anterior interosseous nerve of the left forearm with serious consequences. The effect of hand and foot microsurgery on the pathological tissue and parallel nerve anastomosis was effective, which provides further success for clinical treatment.”
4) Introduction

a. Only one paragraph. I advise you to split it into 2 paragraphs; one for descriptive part and the other for challenging part. b. The challenging part is deficient. c. Please specify the treatment option

Response: Thank you for the suggestion. Thank you for the comments. Modifications have been made as required. And we also have made additions in the Introduction section of the original text, highlighted in red.

“Hourglass-like constriction neuropathy is a complex neurological disorder, the cause is unknown, but is typically characterised by hourglass constriction of nerve trunks (nerve branches). The clinical features are characterised by sudden onset of pain followed by dysfunction of the motor or sensory functions innervated by the corresponding nerve\[^1\text{-}^3\]. Hourglass-like constriction neuropathy has not been studied separately for its epidemiology as most scholars consider it to be the result of an altered structural pathology\[^4\].

The preoperative diagnosis of this disease is challenging, and the definitive diagnosis is usually made after surgical exploration. Ultrasound and Magnetic resonance neurography (MRN) are useful in diagnosing nerve hourglass constriction, but are usually not visualised by conventional magnetic resonance imaging (MRI) \[^5\]. Due to the rarity of the disease and the limitations of the investigations, in general, many physicians will often misdiagnose it as neuritis or some localised nerve entrapment syndrome based on its signs and symptoms, but they are different. The latter is often misdiagnosed because their symptoms are particularly similar, mostly due to aseptic inflammation or viral infection and mechanical compression, whereas the former is more often a neurological organic lesion. On the other hand, the treatment of these diseases can be very challenging and although there are many surgical options, such as epineurectomy and neurolysis, resection and neurorrhaphy or nerve grafting, the results are not satisfactory\[^6,7\].

We report here a case of hourglass-like constriction of the anterior interosseous nerve in the left forearm, which recovered after surgical treatment. In addition to this, we have retrospectively analysed cases that have been
reported as hourglass-like constriction treatments in the last decade to analyse their efficacy.”

5) Case presentation a. Please take care of the journal style. B. Please strict to the subheading, for example in the chief complaint you talk about the history of the present illness.

Response: Thank you for the suggestion. Thank you for the comments. Modifications have been made as required. And we also have made additions in the Case presentation section of the original text, highlighted in red.

“Chief complaint: The patient, a 47-year-old male piano tuner, complained of weakness in his left hand, with no apparent traumatic cause of flexion or extension of the distal phalanges of his left thumb for two months.

History of present illness: The patient has no family history of alcohol or tobacco addiction and was in good overall mental condition.

Personal and family history: No significant medical history.

Physical examination:

Left thumb long flexor tendon strength grade 4, left index finger deep flexor tendon strength grade 0, left thumb short flexor strength grade 5, left index finger short flexor strength grade 5, no significant abnormalities of superficial skin sensation in the left hand and left forearm. The palmar aspect of the left wrist is flatter than that of the right wrist (anterior rotator muscle), and there are no significant abnormalities in finger movement or blood flow in the remaining fingers.

Digital radiography examination:

The left ulnar radius is regular in shape with continuous bone cortex and
clear bone trabeculae, with no obvious signs of bone destruction. The distal ulnar flexor and flexor carpal joint gaps were moderate and there were no obvious abnormalities in the surrounding soft tissues (Figure 1).

Colour Doppler examination:

Widening of the median nerve cross-section over the left elbow, left side wide (0.48 cm × 0.29 cm,) hypoechoic, star grid-like changes, the left side of the median nerve at the elbow is about 0.54 cm × 0.29 cm wide (right side is about 0.52 cm × 0.27 cm wide) locally hypoechoic, local nerve bundle thickness varies, one obvious narrowing is visible, local nerve bundle width is about 0.08 cm, proximal segment is 0.17 cm, the distal segment is 0.14cm. The body surface was marked and the median nerve at the wrist was approximately 0.62 cm × 0.23 cm wide on the left (0.76 cm × 0.38 cm wide on the right).”

6) Physical examination: There is no verb in this sentence

Response: Thank you for the comment. As we used British English, which may have caused the reviewers to misunderstand, our native speaker reviewed it again and revised it as well.

7) DR examination???

Response: Thank you for the comment. Modifications have been made as required.

“Hourglass-like constriction of the anterior interosseous nerve in the left forearm”

8) 0.48 cm × 0.29 cm. please do the same for similar things in the manuscript.

Response: Thank you for the suggestion. Modifications have been made as required.

9) a. You can add the possible differential diagnosis. b. You said there is no
apparent traumatic cause. Then, how you reach to this diagnosis? 

Response: Thank you for the comments. Modifications have been made as required. Based on our surgical exploration of the visual exposure, we gave a straightforward final diagnosis: Hourglass-like constriction of the anterior interosseous nerve in the left forearm.

10) You didn’t mention Figure 1.

Response: Thank you for the comment. We have added it on page 5, line 95.

11) a. The discussion focuses only on review of the literature without refereeing to the presenting case. Therefore, I advise to rewrite it again. b. the first paragraph is long and contains a lot of information. I advise to split it into three paragraphs; the first for general information, the second for clinical presentation, and the third for the diagnosis. c. You discuss only the gender of the reported cases. d. Is there any limitation to the study.

Response: Thank you for the comments. We have reworked the discussion section and added content as required and highlighted it in red.

“Englert first described the hourglass constriction of nerves in 1978, but did not elaborate on its pathogenesis[8]. In recent years, many medical scholars have put forward numerous hypotheses and theories regarding to the pathogenesis of the disease, mainly divided into: the external structural compression theory[6], the repetitive motion theory[9], the nerve torsional displacement theory[6,10], the inflammatory response theory[11,12] and the inflammatory response with repetitive motion theory[13], but ultimately no unified and accepted conclusion has been reached.

However, the morphological features of the nerve lesions are more consistent, with the main nerve trunk or its nerve branches showing significant narrowing in the form of bundle wraps. Outer nerve membrane continuity may be present, but most of the nerve bundles have been dissected[14]. The disease's
main symptom is a sudden onset of pain in the corresponding innervated area, followed by flaccid paralysis or restriction of movement in the affected muscles[1,15]. The presentation of this lesion is very similar to that of conditions such as spontaneous peripheral nerve palsy, which can be difficult to distinguish clinically and is therefore often overlooked, leading to delays in treatment and compromising recovery[1,16].

Prior to the development of MRN and high frequency ultrasound imaging, the clinical tendency was to attribute the cause of dysfunctional finger movements as well as muscle weakness to spontaneous peripheral nerve palsy, as at that time hourglass-like constrictions could only be diagnosed by surgical exploration. With advances in medical imaging, more patients diagnosed with spontaneous peripheral nerve palsy are being found to have hourglass-like constriction lesions in their nerves[17,18]. In addition, the MRN examination helps to identify the exact location of the neuropathy before surgery is required, so that surgery can be performed with less time, smaller incision areas and more precise treatment[19]. Certainly, high frequency ultrasonography is a reliable, convenient and non-invasive diagnostic imaging method for accurately locating the hourglass-like constriction neuropathy and extent of neuropathy in the anterior interosseous nerve[20].

The treatment of this disease is still somewhat controversial, with a general preference for conservative treatment first, and surgical intervention being beneficial in selected patients who do not recover promptly within 3 months and have hourglass-like lesions confirmed on preoperative examination[1]. In addition, the use of nerve grafting is definitive for patients with nerve defects greater than 2 cm[6]. Failure to perform surgical treatment in a timely manner is thought to prevent the regeneration of nerve axons and affect the patient's recovery of function.

We reviewed cases of peripheral nerve disease due to hourglass-like constriction over the last 10 years (Table 1). We noted that the proportion of patients presenting with hourglass-like constriction was much higher in men
than in women\cite{6,7,21,22}. This may be due to differences in daily activities between men and women, with men engaging in more repetitive physical activities that are more likely to lead to nerve entrapment and compression\cite{23}, but whether this leads to hourglass-like constriction needs to be further explored. In addition, in our retrospective study, we found that there is no age limit for this type of disease, which can occur in children as well as in the elderly, and that the disease is mostly found in the motor nerves of the upper limbs, which we hypothesise is related to the fact that the nerves of the upper limbs mostly innervate the limbs for delicate manipulations and their neuroanatomical location. In the treatment of hourglass lesions, we have found that conservative hormonal treatment is not particularly effective, whereas surgical release of the nerve and resection of the lesion with anastomosis seems to work well, and the prognosis is significantly better in young people than in older people\cite{24}. We, therefore, report here a case of hourglass-like constriction of the anterior interosseous nerve in the left forearm, which was treated surgically by our excision of the diseased tissue and parallel nerve anastomosis, followed by a 6-month continuous follow-up period during which the patient was asked to strengthen his functional exercises, resulting in a gradual recovery of his symptoms. This has provided more experience in clinical treatment and has enriched the success stories of effective surgical treatment.

However, there are still some limitations to this study, the main cause of the problem is due to the insufficient volume of literature and its clinical cases. For example, in this study we only analysed the reported literature, most of which had significant treatment outcomes, but I believe that most of the cases with poor treatment outcomes were not reported, so the limited amount of data in the literature may lead us to conclude that the results are not factually accurate; on the other hand, we reviewed the literature from the last 10 years and did not combine it with previous studies, which may also have an impact on our summary and may also be less accurate in terms of our summary of treatment modalities and efficacy. More comprehensive clinical studies are
needed in the future to confirm the effectiveness of their treatment modalities and their efficacy.”

12) a. References. b. Should follow the journal style (bold the first author of each reference.

Response: Thank you for the comments. Modifications have been made as required.

13) a. It is better to substitute the name of the first column "reference" with the "authors". b. It is better to add 2 columns; one for the year and the other country of the study. c. Separate the Sex/age into 2 columns. Besides, change the sex into gender and add to the age "per years". d. I advise to reduce the writing in certain columns. e. Please specify from which data base you did the review.

Response: Thank you for the comments. Modifications have been made as required. We have added the country of the study and the year in which the article was published to the first column.

Table 1 Review of peripheral nerve disease caused by hourglass-like constriction neuropathy in the last 10 years

<table>
<thead>
<tr>
<th>Author/s/country of study (yr)</th>
<th>Gender/age (yr)</th>
<th>Symptoms</th>
<th>Nerve explored</th>
<th>Imagining</th>
<th>Inspection result</th>
<th>Treatment options</th>
<th>Prognosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yasunobu Nakagawa, Japan (2018)</td>
<td>M/9</td>
<td>Pain in the left arm with severe paralysis when extending</td>
<td>Brachial Plexus in the Posterior Cord</td>
<td>MRI, ultrasound</td>
<td>There is mild diffuse enlargement and high intensity</td>
<td>Surgical nerve exploration, nerve release</td>
<td>Strength starts to return 3 week</td>
</tr>
<tr>
<td>Du Hwan Kim, South Korea (2019) [19]</td>
<td>F/26</td>
<td>Pain in the scapula, difficulty in raising the left arm, relief of pain in the wrist, thumb and fingers</td>
<td>of the left brachial plexus nerve.</td>
<td>Oral steroids, topical steroid injections</td>
<td>Muscle strength approach normal</td>
<td>Multiple hourglass-like contractions were found in the suprascapular nerve</td>
<td>MRN</td>
</tr>
</tbody>
</table>
within 10 days, weakness in the shoulder.

<p>| Du Hwan Kim, South Korea (2019) [19] | M/42 | Pain in the scapula and deltoid area, weakness in the left shoulder | suprascapular nerve | MRN | Focal contraction of the suprascapular nerve | Oral prednisolone, injectable steroid | Back to normal after 15 months. |
| Du Hwan Kim, South Korea (2019) [19] | M/52 | Weakness in the left shoulder and drooping of the left wrist. | suprascapular nerve, radial nerve | MRN | Diffuse swelling of the C6 nerve and two focal contractions of the suprascapular nerve. | Intravenous steroids | The shoulder joint recovered after 3 months with no improvement. |</p>
<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Symptoms</th>
<th>Nerve Impacted</th>
<th>Test</th>
<th>Treatment</th>
<th>Improvement after</th>
</tr>
</thead>
<tbody>
<tr>
<td>Du Hwan Kim, South Korea (2020) [3]</td>
<td>M/19</td>
<td>Drooping left wrist, dorsal sensory deficit of left wrist.</td>
<td>Radial nerve</td>
<td>MRN</td>
<td>Focal contractio of left radial nerve at 2.</td>
<td>Surgical nerve release</td>
</tr>
<tr>
<td>Name</td>
<td>Gender</td>
<td>Age</td>
<td>Symptom Description</td>
<td>Imaging</td>
<td>Condition</td>
<td>Intervention</td>
</tr>
<tr>
<td>-----------------------</td>
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<td>---------------------------------------------------------------------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>Karthik R Krishnan, USA (2020)</td>
<td>F/58</td>
<td></td>
<td>Pain in the right shoulder with weakness in abduction.</td>
<td>supras capular, axillary, phrenic nerves</td>
<td>MRN, ultrasound</td>
<td>Focal contraction at 2 phrenic nerves.</td>
</tr>
<tr>
<td>Alexander Loizides, Austria (2015)</td>
<td>M/26</td>
<td></td>
<td>Radial deviation of the wrist during wrist extension; impaired extension of the metacarpophalangeal joint; impaired extension of the radial nerve</td>
<td>radial nerve ultrasound</td>
<td>Focal contraction of radial nerve in 3 places.</td>
<td>Surgical nerve release 3 mont hs after the operation, there was a marked improvement in symptoms.</td>
</tr>
</tbody>
</table>
fingers at the metacarpophalangeal joint; impaired abduction and adduction of the thumb.

| A Kodama, Japan (2015) [27] | M/37 | anterior interosseous nerve | ultrasound | Focal contraction at 3 anterior interosseous nerves. | Surgical nerve release | Significant improvement in symptoms 5 months after surgery |

14) a. You didn’t mention the figures in the text. b. You must remove the writing from the figure. c. Please add view after the word "lateral". D. Please replace it with plain X-rays.

Response: Thank you for the comments. Modifications have been made as required and highlighted in red.
“Figure 1 Lateral view (A) and orthopantomogram (B) X-rays of the left forearm show no significant abnormalities.”

15) The legend needs more detail.

Response: Thank you for the comments. Modifications have been made as required and highlighted in red.

“A-B: Exposure of the diseased nerve; C: Excision of approximately diseased tissue; D: Successful nerve repair anastomosis.”

Thanks to Xin Li and Tingting Gai for the final revisions and additions to the manuscript. We decided to add two authors. I hope you can agree with our decision. Thank you!
Xin Li: 877139779@qq.com

Tingting Gai: gtt18764068267@163.com

Reference:
7. Wu P, Yang JY, Chen L, Yu C. Surgical and conservative treatments of complete spontaneous posterior interosseous nerve palsy with hourglass-


24662504 DOI: 10.1227/NEU.0000000000000350


Dear Editor,

Re: manuscript reference no. 85242

Thank you for sending the referees’ comments on our manuscript entitled: Hourglass-like constriction of the anterior interosseous nerve in the left forearm: A case report and literature review.

The authors would like to thank the reviewers for providing feedback on this manuscript, which was both positive and constructive. We have integrated these comments and suggestions into our revised manuscript, highlighting the edits through track changes. We have also separately summarized the reviewers’ feedback and listed our responses as enclosed here for your reference.

I hope you find the revised manuscript satisfactory and acceptable. Should you have any further questions or comments, please do not hesitate to contact us.

Yours sincerely,

Yu Zhou (on behalf of all authors)
Revision reviewer #1

Specific comments to authors

All changes as suggested are done and accepted.

Revision reviewer #2

Specific comments to authors

I appreciate the great effort of the authors in revising the manuscript. The following points should be revised to improve the presentation of the study. 1. Some words or sentences need to be revised due to spelling or grammar mistakes as I highlighted them in the main manuscript file. 2. The writing of the chief complaint and history of the present illness are similar. 3. The table and figures should be redesigned according to the style of the journal. Good luck

Response to the Reviewer’ Comments

1. Some words or sentences need to be revised due to spelling or grammar mistakes as I highlighted them in the main manuscript file.
   
   Response: Thank you for your comments. We reviewed it again and modified it.

2. The writing of the chief complaint and history of the present illness are similar.

   Response: Thank you for your comments. The History of present illness has been revised as follows:

   Over the past 2 months, his condition has progressively deteriorated with weakness in his left hand, as well as ancient flexion weakness in the distal left thumb and significant restriction of movement.

3. The table and figures should be redesigned according to the style of the
Response: Thank you for your comments. It is due to problems with the platform system before that figures and tables cannot be displayed normally. Currently, we have re-uploaded figures and tables in manuscript.