



SDI Review Form 1.6

Journal Name:	International Journal of Biochemistry Research & Review
Manuscript Number:	Ms_IJBCRR_34351
Title of the Manuscript:	25-OH-Vitamin D level and calcium/phosphorus metabolism disorders in patients living with HIV in Abidjan
Type of the Article	Original Research Article

General guideline for Peer Review process:

This journal's peer review policy states that **NO** manuscript should be rejected only on the basis of '**lack of Novelty**', provided the manuscript is scientifically robust and technically sound.

To know the complete guideline for Peer Review process, reviewers are requested to visit this link:

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PART 1: Review Comments

	Reviewer's comment	Author's comment (if agreed with reviewer, correct the manuscript and highlight that part in the manuscript. It is mandatory that authors should write his/her feedback here)
Compulsory REVISION comments		
Minor REVISION comments	- I'm sorry, but I'm confused with the exact number of individuals. In the abstract it appears "a cohort of 220 samples ... including 110 HI-negative controls and 110 samples from PLHIV", while in the section MATERIAL AND METHOD (line 33), it appears "a cohort 220 adult subjects HIV positive. ..The controls consisted of HIV-negative subjects. " It gives rise to confusion, are they 220 patients, or only 110 are sick? - Line from 67 to 69: You have a paragraph from a previous revision. Remove it. - Line 75: Is named Figure 1, but the true figure, on page 7, does not have a foot letter with "Figure 1". - Line 80: It is not table 2, it is really TABLE 1. - Line 81: Another parenthesis is missing after Table 1. - Please, take care of the aesthetic detail of not cutting the table 1 in two fragments. It appears between pages 5 and 6. - Remove the underlining in these 3 bibliographic citations: numbers 8, 19 and 20.	- Sorry, it is a total of 220 cohort samples including 110 positive-HIV adults and 110 control (negative-HIV adults). ABSTRACT section and Line 32 in MATERIAL AND METHOD section All the corrections are highlighted in yellow colour in the text: -Line 67 to 69: OK, this paragraph is removed - The missing foot letter is added: see Page 8 - Line 80: Ok, read Table 1 instead of Table 2 - Line 81: OK, 2 parentheses appear now. - We reunified the Table 1. It appears now on Page 6. - Ok, we eliminated the unnecessary underlining in the 3 references (N0. 8, 22, 24; Page 9, 10 and 11)
Optional/General comments	- Line 38: It is OK. it is very important and correct that you have taken this measure into account. - The methodology and the statistical analysis carried out are adequate. - Lines from 96 to 98: <i>Sufficiency in 25 (OH) vitamin D reserves observed in our study could be explained due to the fact that Cote d'Ivoire is a tropical country</i>	- Line 38: Thank you for this remark - METHODOLOGY: Ok - Thank you very much. Line 99 to 101 in the new version, we have added the cited article in the text (ref. n0. 19).



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	with heavy sunshine, the major intakes pathway of vitamin D to the body is the way of skin synthesis [18]. I completely agree, in the article <i>Int J Environ Res Public Health</i> 2016; 13 (10) (DOI: 10.3390 / ijerph13101019) discloses that major role for exposure to solar ultraviolet radiation in determining 25 (OH) D levels is apparent, with the dietary contribution being minor. - Lines from 98 to 99: <i>The deficiency cases observed in control subjects may be due to consumption of diets poor in vitamin D, since its supply has two origins (food and synthesis). It would also be interesting to add deficiency by using sunscreens with a protective factor of 8 or higher (Am J Clin Nutr 2004; 79 (3): 362-71), and renal and/or hepatic pathologies such as cholestatic hepatitis (Food and Nutrition Board, Institute of Medicine, Vitamin D. Dietary Reference Intakes: Calcium, Phosphorus, Magnesium, Vitamin D, and Fluoride, Washington DC: National Academic Press, 1999: 250-287).</i> - Lines from 103 to 105: <i>Furthermore, there is no relationship between the level of calcium and phosphorus metabolism disorders, 25 (OH) vitamin D and the degree of immune suppression [20]. This agrees very well with the results obtained in this work.</i> - Lines from 123 to 124: <i>"Calcium and phosphorous metabolism disorders observed during HIV infection are likely due to a deficiency of 1.25 (OH) 2 vitamin D". More than likely, there is an article that shows how women with HIV suffer from osteopenia, where there is a dissociation between lowered markers of bone formation rate and the increased bone resorption, with decreased levels of 1,25 (OH)2D which contribute to a negative calcium</i>	- Ok, see line 102 to 104 (new version of the manuscript): These references numbers are 20 and 21. - Thanks, line 118 to 119 (new version) - Lines 111 to 117 in the new version: -We adjusted the discussion by citing the article of Teichmann et al (J Infect 2003) mentioned (Ref. N0. 23)
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	balance and inhibition of bone formation. In addition, they determined that 1,25 (OH)₂D is known as an endogenous immune modulator suppressing formation of activated T cells and cell proliferation (J Infect 2003; 46 (4): 221-7). - There is high prevalence of vitamin-D deficiency in people living with HIV (PLHIV), however this is not what happens here and is duly justified as the article comments because it is a very sunny area. You commented that it is required to complete this study with the analysis of PTH, calcitonin and nuclear vitamin D receptors. In the literature, it is already described how in these HIV patients treated with vitamin D supplements with calcium, they can increase vitamin levels D and reduce the level of PTH (Recent Pat Antiinfect Drug Discov 2016; 11 (1): 59-67). The effect of tenofovir disoproxil fumarate (TDF) on bone metabolism and bone mass in HIV-infected adolescents was correlated with PTH elevation and bone turnover dysregulation (Antivir Ther 2016, in press: doi: 10.3851/IMP3103). We have already stated that PLHIV frequently has osteolytic bone disease, where HIV-1 infection induced larger osteoclasts, enhanced the expression of mRNAs for osteoclast specific marker molecule (calcitonin receptor), and up-regulated osteoclast bone resorption activity (Retrovirology 2015; 12:12). And finally, it has been described that the relationship between vitamin D receptor variants and ethnicity, disease or treatment response in the South African population groups demonstrated complex interactions between genetics, epigenetics and the environment (Int J Environ Res Public Health 2016; 13(10)): DOI:10.3390 / ijerph13101019).	- Thanks for all the bibliographic details in this paragraph. They will guide us in analyzing the future studies in HIV-infected patients of Côte d'Ivoire. Especially the relationship between the variants of vitamin D receptors and ethnicity, disease or response to treatment ...
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