



SDI Review Form 1.6

Journal Name:	International Journal of TROPICAL DISEASE & Health
Manuscript Number:	Ms_IJTDH_24379
Title of the Manuscript:	Prevalence of Intestinal Parasites in Cancer Therapy Recipients with Concurrent Diarrhea
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:

(<http://www.sciencedomain.org/page.php?id=sdi-general-editorial-policy#Peer-Review-Guideline>)



SDI Review Form 1.6

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	The reviewed MS 24379 reports on a study of parasites in Ca patients in an Egyptian hospital. 1) The study is biased, since the patients were chosen as having diarrhea while receiving chemotherapy. Therefore, a paragraph on the limitations of the study should be welcome. 2) No other laboratory examinations were performed on those patients, like culture of bacteria in stool or the presence of viruses. Ca patients develop diarrhea many times just because of the treatment; therefore, stating that the parasites were the cause of diarrhea is not tenable. 3) three stool samples were collected. What was the time spacing between each sample? 4) I would like to ask the authors how do they identified <i>Entamoeba histolytica</i>. Was there blood and mucus in stool? Did they see <i>E. histolytica</i> trophozoites with engulfed red blood cells? Or did they only see tetranucleated cysts? If the last premise is the case, then it should be called <i>Entamoeba histolytica/E. dispar</i>, unless molecular testing was performed, which is not discussed in the MS. In other words, what was seen was <i>E. histolytica/E. dispar</i>, which are two different species that can be separated by molecular techniques, but not by microscopy. 5) when did the diarrhea start in the selected patients? Did the patients have diarrhea before, when not taking Ca treatment? How often did they present with diarrhea? Before, during or after treatment? The diarrhea was not	1- We intended to include cancer patients with diarrhea due to more probability of misdiagnosis for diarrhea cause as due to therapy and as you notice we classify diarrheic patients into parasite infected and parasite non-infected (possibly no infection just due to chemotherapy or other viruses bacteria). 2- We stressed on parasites as it is our area of research. These are parasite associated cases and our results are confirmed later on after treatment of those cases with anti-parasite medication and all diarrhea-associated parasites were stopped. 3- Three consecutive stool samples were performed (one every other day for 3 days) due to known erratic excretion of parasites in stool. 4- <i>E. histolytica</i> was identified according to the morphology of trophozoite as in diarrheic stool trophozoites are more excreted than cysts. So no molecular diagnosis was needed for differentiation between the 2 species. 5- We specify the type of diarrhea in material and methods section (line 34-37). 6- Yes. Subjects with positive parasites received therapy according to CDC protocol (Kappagoda, 2011). Either with metronidazole 10 days for <i>E. histolytica</i>, <i>B. hominis</i> or 5 days for <i>G. lamblia</i>) in a dose of 50 mg/kg/day in 3 divided doses. Patients with <i>Cryptosporidium</i> received



SDI Review Form 1.6

	classified: how many episodes per day, how many days, were the stools liquid? (runs like water) or was the stool diarrheic? (conforms to the container) was mucus present? Was any blood present? Was the diarrhea accompanied by abdominal pain? Vomiting? Nausea? 6) Was there any treatment offered to patients, especially when it was believed that the parasites were the cause? 7) in endemic countries, <i>Giardia duodenalis</i> causes diarrhea (sometimes, not always) mainly in children; how does <i>Giardia</i> behave in the general population in Egypt? Many studies in other countries have found more giardiasis in the healthy controls than in the diarrheic patients. 8) the authors state to have stained for microsporidia, but have no comments on the results. Where there any microsporidia? What species? 9) how did they differentiate <i>Cryptosporidium</i> from other intestinal apicomplexa? 10) It is well known that <i>Cryptosporidium</i> causes diarrhea in any patient, but there is no treatment and immunocompromised patients may die. What happened to those infected patients in Egypt? Also, it is well known that the excretion of the oocysts can be prolonged even when there is no more diarrhea. Any comments on cryptosporidiasis as observed in Egypt? 11) Line 111: "healthy controls with diarrhea" (?). Please explain. 12) Lines 20,21: Gram (the stain) with capital letter. 13) Line 129: table (2) should read: Table 2. The English language requires some improvement in general. The spelling of parasites (<i>Iodamoeba bütschlii</i>) requires attention. 14) some of the "parasites" diagnosed are indeed commensals. 15) To be able to compare results among similar studies	paromomycin 10 mg/Kg three times per day for 10 days. Patients with Microsporidia received albendazole 800mg/d divided into two times per day for ten days plus IV fluid and electrolytes replacement. After the end of parasite treatment courses, diarrhea stops and re-examination of stool indicated clearance of parasites. 7- Our aim wasn't to compare parasite prevalence related to healthy controls but to shed light on the problem in cancer patients. 8- We found microsporidia in 7 cases out of 145 total cases as shown in table1, 2. We didn't use electron microscope to differentiate between species (our study relied on ordinary stool exam in diagnosis; the most commonly widely used method. Stains for microsporidia were in material and methods section lines: 52-54. 9- By staining and morphology. 10- Replied in 6. 11- In discussion we compared our results to studies examining healthy subjects to present the high prevalence of infection in our target group. 12- Corrected 13- Corrected 14- We didn't say pathogenic parasites from the start besides most infections were multi-parasitic. 15- We compared our results to both types of studies those with immune deficiency similar to ours or with healthy individuals to indicate the problem (higher prevalence)
--	---	--



SDI Review Form 1.6

	one needs to pay attention to type of population studied, the methodology used, etc., otherwise differences in results will always exist. 16) Is <i>Strongyloides</i> common in Egypt? What is the percentage of infection in the general population? Are there any particular geographical areas in Egypt where <i>Strongyloides</i> is more frequent than in others? Ethical Issues: As asked in Nos. 6 and 10 above, no mention of treatment to parasitized patients. Cryptosporidiasis is a serious infection, as are the rest in immunocompromised patients. I understand the study was observational, not interventional; however, there should have been some provisions to the effect.	
Minor REVISION comments		
Optional/General comments		