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Journal Name:	<u>International Journal of TROPICAL DISEASE & Health</u>
Manuscript Number:	Ms_IJTDH_33459
Title of the Manuscript:	LEPTOSPIROSIS – A RARE CAUSE OF ACUTE ACALCULOUS CHOLECYSTITIS: SUCCESSFULLY TREATED WITH ANTIBIOTICS AND CHOLECYSTECTOMY.
Type of the Article	Case study

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>)



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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	This is an interesting study. 1-How is the follow up of patient at 6 month? 2- "Leptospirosis may correlate with Fascioliasis"(J Kartal TR 2016;27(2):145-146) and (Surg Laparosc Endosc Percutan Tech. 2017 Mar 13. doi: 10.1097/SLE.0000000000000389) I suggest both of these uptodate studies for the references.	Dear sir/madam, thank you very much for your comments. 1. Our patient contracted the disease only 4 months ago, which is why we'd only just completed his 3-month follow-up (at the time of preparation of this report). 2. We have gone through the 2 studies you had sent us. Our feedback: i. Our patient presented with acute febrile syndrome for which we ran tests for majority of the common diseases seen locally, but the history of contact at a slaughterhouse made us suspect leptospirosis at the very outset. Moreover, human fascioliasis in India has been limited to a few case reports & incidental findings on imaging/endoscopy mainly from north/northeastern part of India, but not common in our area. ii. At the time of admission, history of our patient didn't correlate with the acute hepatic phase of fascioliasis clinically and he didn't have peripheral eosinophilia. Ultrasonography at the time of admission did not show any features that are commonly seen in Fascioliasis. iii. Present case responded with antibiotics appropriate for Leptospirosis which was diagnosed with the support of IgM antibodies for Leptospira (ELISA), elevated liver enzymes decreasing and with alkaline phosphatase levels being normal throughout. Other routine investigations (as mentioned in the case report) including stool analysis were



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		unremarkable. iv. As the patient started to clinically improve, on day 6, patient developed features suggestive of acute cholecystitis. Repeat abdominal ultrasonography showed partially distended gallbladder with sludge (as shown in Fig.1 of the report). Rest of the hepatobiliary system including CBD were normal without evidence of gallstones. Nor there is any other abnormality of the gastrointestinal system noted during ultrasound. This is probably in contrast to chronic biliary phase of fascioliasis which is a late phenomenon. v. Due to the lack of the relevant historical, clinical and radiological features (for Fascioliasis or otherwise), we did not see an indication to perform a colonoscopy in this patient. vi. During the surgery, the above ultrasonographic features were confirmed and histopathological examination of the surgical specimen didn't reveal any cholelithiasis but revealed loss of mucosa, signs of tissue necrosis & suppurative inflammation, but microbiological results did not reveal any organisms. To conclude, in contrast to chronic-biliary-phase of fascioliasis wherein calculous cholecystitis was reported late in the clinical presentation, leptospirosis has been reported with acute acalculous cholecystitis as a presenting feature or during the period of treatment early on, as in our patient. Although we considered other causes of acute febrile illness during evaluation, due to the above-mentioned reasons and a thorough review after your suggestions, with all due respect, we differ in considering Fascioliasis as a possibility in <i>this</i> particular case study.
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Minor REVISION comments		
Optional/General comments		