



SDI Review Form 1.6

Journal Name:	<u>International Journal of TROPICAL DISEASE & Health</u>
Manuscript Number:	Ms_IJTDH_33598
Title of the Manuscript:	MYCOBACTERIUM TUBERCULOSIS AND HIV CO -INFECTIONS AMONG PATIENTS ATTENDING A NIGERIAN TERTIARY HEALTH CENTER.
Type of the 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>)



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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	1 – What was the basis of calculation of sample size and how were they selected the patients? 2 – The authors found that RIF resistance and treatment naïve was 2.6% but they don't explain why this finding. 3 – Did the authors collect information about contact of cases? If yes, what is the association with RIF resistance? 4 – In 2016 fig.1, the authors had more notification of patients but most of them were little MTB+. Is there some explanation for this finding?	1. Sample size was obtained by Benneth et al, 1991 with a local prevalence of MTB of 21.5%³. However, this sample size of 259 was increased to 2969 (N X11) for adequate coverage and proper determinant. The subject criteria included all patients above 15 years, suspected of pulmonary TB, treatment naïve(new) and re-treated cases irrespective of HIV status. 2. Re treatment cases in the study were previously treated patients who were still sputum smear-positive and had a 9.2% higher risk of RIF drug-resistant TB than the 2.8% RIF drug resistance seen in treatment naïve (or new) patients. These re –treatment cases were the Categories II & IV which included; the Relapse cases, treatment after failure, treatment after default, Chronic and MDR-TB cases. Occasionally, treatment naïve or new patients present with resistance mostly when they were infected by resistant strains. 3. NO 4. It is an interesting observation that in 2016, a 2079 astronomically high number of patients were tested for MTB with only a 44 very few MTB cases detected.



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		An explanation to this may be a change in hospital policy to more advocacy and awareness creation on MTB diagnosis in 2016. Again, tests for GeneXpert were no longer restricted to Re-treatment cases.
<u>Optional/General</u> comments		