Revision

Manuscript Number
13481

Manuscript Title
Successful, but complicated faecal microbiota transplantation in a patient with spinal cord injury and severe recurrent Clostridium difficile infection.

Dear Editor in chief,

we gratefully thank all reviewers for their comments, thoughts and helpful discussion! In detail we have followed their remarks as follows:

Comments to Reviewer 1:

- The "extensive work-up" to reveal an infectious cause is described in more detail.
- Concerning the course of post-colonoscopy bacteremia we absolutely agree. We therefore have weakened our choice of words, but we still believe, that Clostridium-bacteremia could have been the problem. On the one hand laboratory test from the stool might lack. On the other hand the developing time from spores to an effective and therefore SIRS provocing mass of bacteria might last longer than usually and finally most of the bacterial mass might have been attached to the severely destroyed colonic wall.
- The „calculated“ antibiotic therapy indeed refers to case reports, that describe the successful use of tigecycline in Clostridium difficile infection, but also to the general indication „abdominal infection“, particularly as colitis was the only focus in our infectiological work-up.

Comments to Reviewer 2:

- The ineffectiveness of the chosen therapies was pointed out.
- We absolutely agree that all chosen antibiotics show effectiveness against CDI, so that we cannot be absolutely sure that the cure resulted from the antibiotic treatment instead of FMT. Nevertheless, we are convinced that FMT was the winner because all antibiotics (tigecycline, rifaximin and vancomycine) had already been used earlier and Clostridium has not been detected in stool samples.
- We have now specified the antibiotic regimen leading to CDI as well as all antibiotic regimens against CDI. There was no overlap of antibiotics against pneumonia and anti-CDI-therapy.

- We absolutely agree that irritable bowel syndrome and disruption of normal intestinal flora are important differential diagnosis to relapse of CDI. We favour the relapse of CDI because of the clinical presentation and the development of inflammatory response (i.e. leukocyte count, CRP etc.) in all episodes of diarrhea. Furthermore, our patient had symptom-free intervals between the relapses.
- After discussion we decided not to add a paragraph on different dosing regimens because the extent of that discussion would be beyond the scope of the case report.
- C. difficile is now written in italics in the whole manuscript.

Comments to Reviewer 3:

- We have described the work-up to reveal an infectious cause in more detail. The only focus we found was the persisting colitis in CT-scan.
- We have pointed out the specials of the GI-function in SCI-patients more precisely.
- We have corrected the tense.
- The method of Cl. difficile detection was corrected to PCR.
- We added all CDI treatment regimens. We did not use a tapering regimen of vancomycine.

We hope that we have respected all comments and answered all remaining questions. We thank You in advance for Your patience and quality work.

On behalf of all authors

Sincerely

Thorsten Brechmann