

ROUND 1

Lian-Sheng Ma, Science Editor, Company Editor-in-Chief

Editorial Office

Baishideng Publishing Group Inc

World Journal of Clinical Cases

Dear Lian-Sheng Ma,

We appreciate the opportunity to respond to the reviewers' comments and believe that the manuscript has been improved based on their suggestions and recommendations. We have carefully considered each issue that was raised by the reviewers and have provided point-by-point responses in the attached letter and revised manuscript. We would like to thank the reviewers for their constructive criticism. We hope that these changes address your concerns and you will find the manuscript suitable for publication in the *World Journal of Clinical Cases*.

Thank you for your consideration.

Sincerely,

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Responses to Reviewers' Comments

Manuscript: 62450

To Reviewer: 1

Comments to the Author

The author present a case of herpes zoster radiculopathy accompanying severe motor weakness. The patient was diagnosed with an electrodiagnostic study, and complete recovery was confirmed through a follow-up electrodiagnostic study. It is interesting, but still have some case series of segmental zoster paresis of limbs were published.

Author response: We appreciate your in-depth review, which has assisted us in revising our manuscript. Please see our line-by-line responses to the comments below.

Comment 1: For discussion, should we focus more latest literatures.

Author response 1: We agree with the reviewer's opinion that we have to focus on the latest literature about segmental zoster radiculopathy. We referenced recent studies and discussed electrodiagnostic features of segmental zoster radiculopathy on page 9, lines 238–245, as follows.

Discussion

Before

After	Several previous studies diagnosed segmental zoster radiculopathy via electrodiagnostic study ^[13,14] . Chen et al. reported a case of segmental zoster paresis with electrodiagnostic findings of decreased amplitude in several nerves and ASA in clinically involved muscles ^[13] . According to Liu et al., electrodiagnostic study of 8 segmental zoster paresis patients revealed low amplitude of CMAPs or SNAPs with various ASA in all patients ^[14] . Among 8 patients with segmental zoster paresis, 2 were diagnosed with preganglionic lesions (radiculopathy), while 6 patients were confirmed to have postganglionic lesions ^[14] .
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References

13. Chen GB, Tuan SH, Liou IH, Huang HY, Hu YC, Wu SY, Segmental zoster paresis of

unilateral upper extremity: A case report and literature review. *Medicine*, 2020;99(28):e20466 [PMID: 32664058 DOI: 10.1097/MD.00000000000020466]

14. Liu Y, Wu BY, Ma ZS, Xu JJ, Yang B, Li H, et al., A retrospective case series of segmental zoster paresis of limbs: clinical, electrophysiological and imaging characteristics. *BMC Neurology*, 2018;18(1): 121 [PMID: 30131076 DOI: 10.1186/s12883-018-1130-4]

Moreover, we referenced literature published in 2017 and discussed the MRI findings of segmental zoster paresis on page 8, lines 207–214, as follows.

Discussion

Before

After According to Zubair et al., gadolinium-enhanced MRI revealed abnormalities such as nerve signal increment or enlargement in 7 of 10 patients with segmental zoster paresis^[9]. Zubair et al. also reported that all patients with segmental zoster paresis had abnormal findings on electrodiagnostic study^[9]. Moreover, in the case of segmental zoster paresis, electrodiagnostic study can be used to distinguish whether the affected site is the nerve root or the plexus. In present study, electrodiagnostic results demonstrated ASA in muscles on the right C5/6 distributions with decreased amplitude of axillary CMAP, suggesting right cervical radiculopathy.

References

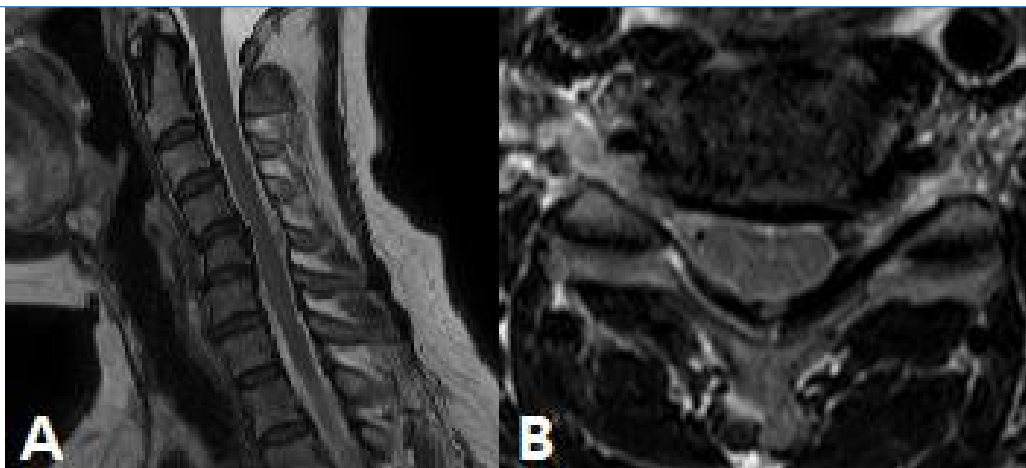
9. Zubair AS, Hunt C, Watson J, Nelson A, Jones LK Jr, Imaging Findings in Patients with Zoster-Associated Plexopathy. *AJNR Am J Neuroradiol*. 2017;38(6):1248-1251 [PMID: 28364009 DOI: 10.3174/ajnr.A5149]

Comment 2: Could you offer clearer pictures of sagittal view.

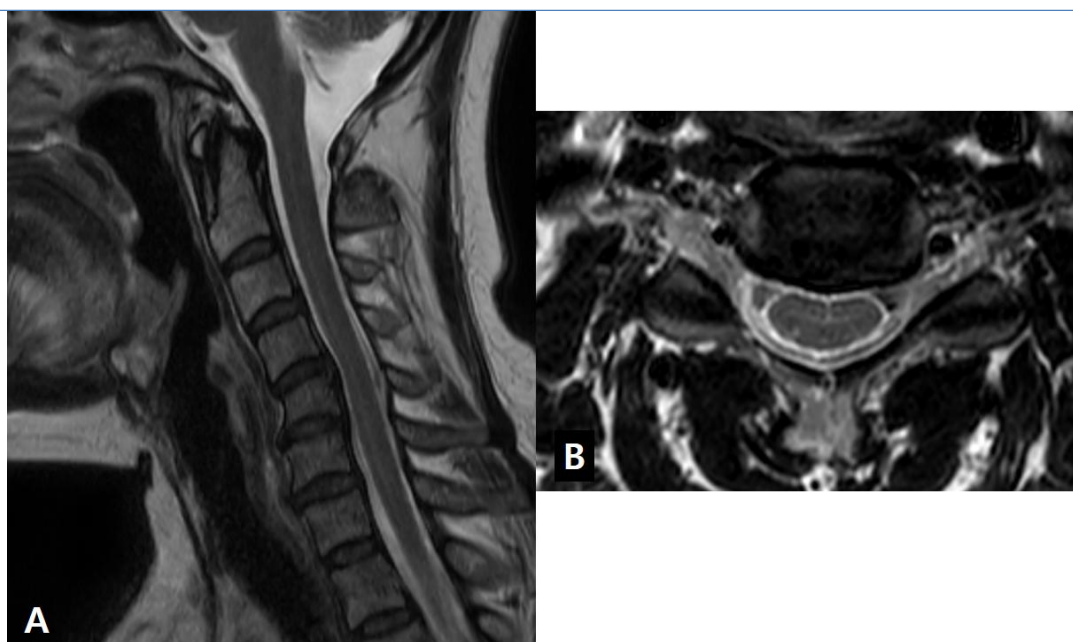
Author response 2: We provided a clearer image of the sagittal view of cervical MRI.

Figure 2

Before



After



To Reviewer: 2

Comments to the Author: In this manuscript, Kim et al. reported a case of herpes zoster radiculopathy accompanying severe motor weakness. Electrodiagnostic study is used in this case to help diagnose and follow-up the recovery. The authors mentioned that clinicians should consider the possibility of post-herpetic paresis, such as herpes zoster radiculopathy, which can be identified and monitored by the electrodiagnostic study. This is an interesting case, and the manuscript is well organized. There are a few limitations in this manuscript.

Author response: We appreciate the reviewer's comments and have revised the manuscript accordingly. Please see the line-by-line responses to the comments below.

Comment 1: The authors mentioned that MRI of the cervical spine revealed no abnormal signal intensity of the spinal cord or intervertebral disc herniation. However, Figure 2 showed cervical kyphosis of C4-6 (especially C4-5) and degeneration of cervical vertebra, indicating that intervertebral disc herniation or osseous compression may exist.

Author response 1: We appreciate your question, and your point is valid. We mentioned that the patient's cervical MRI revealed cervical kyphosis and spondylosis with spur formation at C4–C6. Further, mild intervertebral disc herniation at C4–C5 without the evidence of nerve root compression was also noted on MRI. We described the abnormal findings of cervical MRI on page 5, line 133–136 as follows.

Imaging examinations

Before	Additionally, magnetic resonance imaging (MRI) of the cervical spine revealed no abnormal signal intensity of the spinal cord or intervertebral disc herniation (Fig. 2).
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After	Magnetic resonance imaging (MRI) of the cervical spine revealed cervical kyphosis and spondylosis with spur formation at C4–C6 (Fig. 2A). Mild intervertebral disc herniation at C4–C5 without evidence of nerve root compression was also noted on MRI (Fig. 2B).
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Considering that there was no definite evidence of nerve root compression on cervical MRI and acute motor weakness appeared after skin rash, it is likely that herpes zoster radiculopathy caused the patient's motor weakness rather than cervical disc herniation.

However, we could not completely rule out the possibility of cervical root irritation caused by cervical disc herniation. We described these findings as a limitation of our manuscript on page 10, lines 255–261.

Discussion

Before

After Second, there were MRI findings of cervical spondylosis and mild disc herniation C4 to C5. Thus, we could not completely rule out the possibility of cervical root irritation caused by cervical disc herniation. However, there was no definite evidence of nerve root compression on cervical MRI. Moreover, considering that acute motor weakness only appeared after skin rash and the patient did not complain of posterior neck pain, it is likely that herpes zoster radiculopathy caused her motor weakness, rather than cervical disc herniation.

Comment 2: In addition, there is no clear mention of which segment Figure 2B represents.

Author response 2: We appreciated the reviewer’s comment. We described the segments of Figure 2 on page 18, lines 366–369.

Figure legend

Before **Figure 2. Magnetic resonance images of the cervical spine.**
A. Sagittal view of magnetic resonance imaging of the cervical spine. B. Axial view of magnetic resonance imaging of the cervical spine. There was no abnormal signal intensity of the spinal cord or intervertebral disc herniation.

After **Figure 2. Magnetic resonance imaging of the cervical spine.**
A. Sagittal view of magnetic resonance imaging of the cervical spine. Cervical kyphosis and spondylosis with spur formation was noted at C4–C6. B. Axial view of magnetic resonance imaging of the cervical spine, between C4 and C5. Mild intervertebral disc herniation was noted at C4–C5 without evidence of nerve root compression.

Comment 3: As has been suggested by the authors, the electrodiagnostic study is a helpful

tool for diagnosis and follow-up of radiculopathy, including herpes zoster radiculopathy. However, it seems that the novelty of this study has not been emphasized in this manuscript. As is well-known, electrodiagnostic study has been widely used to distinguish the causes of muscle weakness.

Author response 3: We appreciate and agree with the reviewer's comment. Electrodiagnostic study has been widely used for differential diagnosis of motor weakness, including in herpes zoster radiculopathy. The novelty of this study is that we identified complete recovery of herpes zoster radiculopathy on follow-up electrodiagnostic study. This case emphasizes that the time course of recovery could be evaluated via follow-up electrodiagnostic study. We described this in a sentence on page 9, lines 249–252 as follows.

Discussion

Before

After The feature distinguishing this study from previous studies is that we confirmed complete recovery via follow-up electrodiagnostic study. To the best of our knowledge, this is the first case report of complete recovery of herpes zoster radiculopathy demonstrated on electrodiagnostic study.

In addition, another novelty of our study is that we highlighted the importance of electrodiagnostic study for estimating severity and lesion extent in segmental zoster paresis. We clarified the text on page 10, lines 269–274 as follows.

Conclusion

Before The findings emphasize that clinicians should consider the possibility of post-herpetic paresis, such as herpes zoster radiculopathy. In addition, an electrodiagnostic study is a helpful tool for diagnosis and follow-up of these cases.

After The findings emphasize that clinicians should consider the possibility of segmental zoster paresis, such as herpes zoster radiculopathy, in the differential diagnosis of acute motor weakness. In addition, electrodiagnostic study is a helpful tool for diagnosis of herpes zoster radiculopathy and for determining the severity and extent of lesions. The course of recovery could

ld be evaluated via follow-up electrodiagnostic study.

Comment 4: It will be more interesting if authors could introduce more about the significance of electrodiagnostic study for such cases. Because according to the patient's data, regardless of whether there is an electrodiagnostic study, it will not affect the treatment strategy and outcomes. On the other hand, what other diagnostic possibilities are there, and how the results of electrodiagnostic study help distinguish these possibilities for this patient.

Author response 4: We appreciate the reviewer's comments. Although segmental zoster paresis is the most common cause of motor weakness after shingles, other neurological complications such as meningoencephalitis or myelopathy should be considered. These neurological complications could be distinguished by MRI and electrodiagnostic study. In fact, the first-line treatment of these complications is the same, intravenous acyclovir. However, electrodiagnostic study could be helpful for determining the severity and extent of lesions. We have discussed the differential diagnosis for these patients on page 8, lines 203–214, as follows.

Discussion

Before

After Electrodiagnostic study is helpful in determining the cause of motor weakness following herpes zoster infection. VZV-induced neurological complications such as meningoencephalitis, myelopathy, and segmental zoster paresis all can cause motor weakness after shingles, and they can be distinguished through MRI and electromyography. According to Zubair et al., gadolinium-enhanced MRI revealed abnormalities such as nerve signal increment or enlargement in 7 of 10 patients with segmental zoster paresis^[9]. Zubair et al. also reported that all patients with segmental zoster paresis had abnormal findings on electrodiagnostic study^[9]. Moreover, in the case of segmental zoster paresis, electrodiagnostic study can be used to distinguish whether the affected site is the nerve root or the plexus. In present study, electrodiagnostic results demonstrated ASA in muscles on the right C5/6 distributions with decreased amplitude of

axillary CMAP, suggesting right cervical radiculopathy.

Reference

9. Zubair AS, Hunt C, Watson J, Nelson A, Jones LK Jr, Imaging Findings in Patients with Zoster-Associated Plexopathy. Am J Neuroradiol 2017;38(6):1248-1251 [PMID: 28364009 DOI: 10.3174/ajnr.A5149]

Comment 5: It's good to note that this patient recovered completely six months after presentation. Readers of the journal may be interested in the detailed protocol of the occupational therapy and electrical stimulation therapy used for this case, as well as the treatment after discharge.

Author response 5: We absolutely agree with the reviewer's comment that the detailed protocol of rehabilitation could improve readers' understanding. We added a description on page 6–7, lines 168–174 as follows.

Treatment

Before After a final diagnosis of herpes zoster radiculopathy, the patient received occupational therapy and electrical stimulation therapy on the right upper extremity during her hospital course to prevent muscle wasting.

After Under the impression of herpes zoster radiculopathy, the patient received comprehensive rehabilitation including occupational therapy and electrical stimulation therapy (EST) on the right upper extremity during her hospital course. The rehabilitation program consisted of maintaining range of motion, strengthening exercises, and enhancing functional skills of daily living. EST was performed to the deltoid and infraspinatus muscles. These rehabilitation treatments were performed for approximately 2 weeks and discontinued after discharge.

Comment 6: The prognosis of motor weakness caused by herpes zoster is relatively good, with 66% of patients with zoster paralysis recovering completely within 12 months and 17% reported to have permanent paralysis. How to understand the value of electrodiagnostic results? Whether they can contribute to the prediction of patients' prognosis?

Author response 6: We appreciate this keen observation. There are limitations to

determining the prognosis of herpes zoster radiculopathy by electrodiagnostic study. However, the severity or extent of the lesions provides useful information. Severity estimation by CMAP amplitude or amount of ASA in involved muscles might be relevant to prognosis. In addition, if there is significant recovery on follow-up electrodiagnostic study, a relatively good prognosis could be expected. We revised the manuscript to describe the relationship between prognosis and electrodiagnostic study on page 9, lines 233–248 as follows.

Discussion

Before

After

There are limitations to predicting the prognosis of herpes zoster radiculopathy through electrodiagnostic results. However, evaluating the course of recovery using electrodiagnostic follow-up can provide useful prognostic information. If there is significant recovery on follow-up electrodiagnostic results, a relatively good prognosis can be expected. The severity of radiculopathy could be estimated through CMAP amplitude or the amount of ASA in the involved muscles. Several previous studies diagnosed segmental zoster radiculopathy via electrodiagnostic study^[13,14]. Chen et al. reported a case of segmental zoster paresis with electrodiagnostic findings of decreased amplitude in several nerves and ASA in clinically involved muscles^[13]. According to Liu et al., electrodiagnostic study of 8 segmental zoster paresis patients revealed low amplitude of CMAPs or SNAPs with various ASA in all patients^[14]. Among 8 patients with segmental zoster paresis, 2 were diagnosed with preganglionic lesions (radiculopathy), while 6 patients were confirmed to have postganglionic lesions^[14]. However, there have not been studies on the correlation between prognosis and the amount of ASA or the decrement in CMAP amplitude, and further clinical trials are warranted.

References

13. Chen GB, Tuan SH, Liou IH, Huang HY, Hu YC, Wu SY, Segmental zoster paresis of unilateral upper extremity: A case report and literature review. *Medicine*, 2020;99(28):e20466 [PMID: 32664058 DOI: 10.1097/MD.00000000000020466]
14. Liu Y, Wu BY, Ma ZS, Xu JJ, Yang B, Li H, et al., A retrospective case series of

segmental zoster paresis of limbs: clinical, electrophysiological and imaging characteristics. BMC Neurology, 2018;18(1): 121 [PMID: 30131076 DOI: 10.1186/s12883-018-1130-4]

Comment 7: The “th” in line 141 Page 5 (On the 12th hospital day) is superscript, and is not consistent with that in line 69 page 3 (On the 12th hospital day). There are many similar inconsistencies in the manuscript.

Author response 7: We appreciate the reviewer’s comments. We have unified all “th” terms in the manuscript and several sentences were revised for clarity on page 5, line 119, on page 5, line 139, on page 6, line 166, and on page 7, line 177 as follows.

Case presentation – Physical examination

Before However, on the 3rd hospital day, she complained of monoparesis in the right upper extremity as follows: shoulder flexor 2-/5, shoulder extensor 3/5, shoulder abductor 2-/5, elbow flexor 2/5, elbow extensor 4/5, wrist flexor 5/5, wrist extensor 4/5, and finger flexor 5/5.

After However, on the 3rd hospital day, the patient complained of monoparesis in the right upper extremity as follows: shoulder flexor 2-/5, shoulder extensor 3/5, shoulder abductor 2-/5, elbow flexor 2/5, elbow extensor 4/5, wrist flexor 5/5, wrist extensor 4/5, and finger flexor 5/5.

Case presentation – Electrodiagnostic evaluation

Before On the 12th hospital day, an electrodiagnostic study was performed to determine the cause of monoparesis in the right upper extremity.

After On the 12th hospital day, electrodiagnostic study was performed to determine the cause of monoparesis in the right upper extremity.

Treatment

Before Based on an initial suspected diagnosis of herpes zoster infection, intravenous acyclovir (250 mg every 8 hours) was immediately administered and continued until the 10th hospital day. Tramadol (37.5 mg daily), acetaminophen (325 mg daily), and gabapentin (600 mg daily) were used for pain

n control.

After	Based on an initial suspected diagnosis of herpes zoster infection, intravenous acyclovir (250 mg every 8 hours) was immediately administered and continued until the 10 th hospital day. Tramadol (37.5 mg daily), acetaminophen (325 mg daily), and gabapentin (600 mg daily) were used for pain control.
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Outcome and follow-up

Before	On the 16 th hospital day, the strength of the right shoulder flexor was slightly improved to 2/5, and the right elbow flexor was improved to 3/5.
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After	On the 16 th hospital day, the strength of the right shoulder flexor was slightly improved to 2/5, and the right elbow flexor was improved to 3/5.
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Comment 8: line 224, page 8, there's an extra space at the end of the sentence "Second, a follow-up electrodiagnostic study was performed at 6 months from onset and was not repeated."

Author response 8: We appreciate the reviewer's comments. We have removed the extra space from the sentence on page 10, lines 262–263 as follows.

Discussion

Before	Second, a follow-up electrodiagnostic study was performed at 6 months from onset and was not repeated .
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After	Third, a follow-up electrodiagnostic study was performed at 6 months from onset and was not repeated.
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To Reviewer: 3

It is interesting to be described by the authors but the readers needs more information on both scientific and useful evidence about this rare disorder. For example, does it resolves spontaneously or needs positive therapy.

Author response: We appreciate your in-depth review, which has assisted us in revising our manuscript. We added more information about segmental zoster paresis and referenced the latest scientific literature.

Author response 1-1: The characteristics of segmental zoster paresis such as the prevalence, levels of major invasion, and the timing of onset of symptoms were described on page 7, lines 188–193 as follows.

Discussion

Before

After	In the present case, dermatologic symptoms and electrodiagnostic findings were consistent with herpes zoster radiculopathy. According to a previous study, approximately 3% to 5% of herpes zoster patients also experienced segmental limb paresis ^[4] . Motor weakness is frequent in the C5–C7 segments, affecting the upper limbs, and in the L1–L4, affecting the lower limbs ^[4] . Generally, motor weakness occurs several days after the onset of skin lesions ^[5] .
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References

4. Kawajiri S, Tani M, Noda K, Fujishima K, Hattori N, Okuma Y, Segmental zoster paresis of limbs: report of three cases and review of literature. *Neurologist* 2007;13(5):313-7 [PMID: 17848871 DOI: 10.1097/NRL.0b013e31811e9d6d]
5. Teo HK, Chawla M, Kaushik M, A Rare Complication of Herpes Zoster: Segmental Zoster Paresis. *Case Rep Med* 2016;7827140 [PMID: 27313622 DOI: 10.1155/2016/7827140]

Author response 1-2: Although segmental zoster in general tends to resolve spontaneously and has a good prognosis, there are reports suggesting that antiviral treatment reduces the

severity and incidence of the disease. We discussed the effects of intravenous acyclovir and rehabilitation treatment for segmental zoster paresis on page 8–9, lines 215–226 as follows.

Discussion

Before

After Previous reports suggested that appropriate antiviral therapy could be effective in reducing the incidence of segmental zoster paresis and the severity of electrophysiologic alterations^[10]. Intravenous acyclovir and steroids are recommended for suppressing infections^[10]. However, according to Kawajiri et al., initial antiviral treatment was not sufficient to prevent motor weakness in patients who developed segmental zoster paresis^[4]. Likewise, the patient in this case report presented with motor weakness despite immediate administration of intravenous acyclovir. Early comprehensive rehabilitation is recommended for all patients with motor weakness secondary to herpes zoster radiculopathy^[11]. Rehabilitation programs prevent disuse atrophy and range of motion limitation, playing an important role in recovery from motor weakness. Further clinical trials are needed to identify the effects of antiviral treatment or rehabilitation in herpes zoster radiculopathy compared with spontaneous improvement.

References

4. Kawajiri S, Tani M, Noda K, Fujishima K, Hattori N, Okuma Y, Segmental zoster paresis of limbs: report of three cases and review of literature. *Neurologist* 2007;13(5):313-7 [PMID: 17848871 DOI: 10.1097/NRL.0b013e31811e9d6d]
10. Mondelli M, Romano C, Passero S, Porta PD, Rossi A, Effects of acyclovir on sensory axonal neuropathy, segmental motor paresis and postherpetic neuralgia in herpes zoster patients. *Eur Neurol* 1996;36(5):288-92 [PMID: 8864710 DOI: 10.1159/000117274]
11. Braverman DL, Ku A, Nagler W, Herpes zoster polyradiculopathy. *Arch Phys Med Rehabil* 1997;78(8):880-2 [PMID: 9344310 DOI: 10.1016/s0003-9993(97)90204-5]

Also, we mentioned that administering antiviral treatment in the early stages might be beneficial to patients with segmental zoster paresis and improve prognosis. We modified the text on page 9, lines 227–232 as follows.

Discussion

Before The prognosis of motor weakness caused by herpes zoster is relatively good, with 66% of patients with zoster paralysis recovering completely within 12 months and 17% reported to have permanent paralysis^[8]. In the present case, the patient showed complete motor recovery and had normal electrodiagnostic results at the 6-month follow-up. However, despite the good prognosis, the disease can worsen, progress, or become complicated due to misdiagnosis and lack of antiviral therapy. Thus, patients with herpes zoster radiculopathy might benefit from an electrodiagnostic study, which can be used to confirm the exact diagnosis and distinguish herpes zoster radiculopathy from other neurologic disorders.

After The prognosis of motor weakness caused by herpes zoster is relatively good, with 66% of patients with zoster paralysis recovering completely within 12 months and 17% reported to have permanent paralysis^[12]. Despite the good prognosis of segmental zoster paresis, permanent paresis can occur due to necrosis in anterior horn cells^[12]. Therefore, administering antiviral treatment in the early stages might be beneficial to patients with segmental zoster paresis and could improve prognosis.

References

12. Gupta SK, Helal BH, Kiely P, The Prognosis in Zoster Paralysis, *J Bone Joint Surg Br* 1969;51(4):593-603. [PMID: 4313433]

Author response 1-3: We mentioned gadolinium-enhanced MRI and electrodiagnostic study in segment zoster paresis as diagnostic tools on page 8, lines 207–210 as follows.

Discussion

Before

After According to Zubair et al., gadolinium-enhanced MRI revealed abnormalities such as nerve signal increment or enlargement in 7 of 10 patients with segmental zoster paresis^[9]. Zubair et al. also reported that all patients with segmental zoster paresis had abnormal findings on electrodiagnostic study^[9].

References

9. Zubair AS, Hunt C, Watson J, Nelson A, Jones LK Jr, Imaging Findings in Patients with Zoster-Associated Plexopathy. *Am J Neuroradiol* 2017;38(6):1248-1251 [PMID: 28364009 DOI: 10.3174/ajnr.A5149]

Response to Editors' Comments

EDITORIAL OFFICE'S COMMENTS

Science Editor

Comments to Author:

(1) Science editor: 1 Scientific quality: The manuscript describes a case report of the complete recovery of herpes zoster radiculopathy based on an electrodiagnostic study. The topic is within the scope of the WJCC. (1) Classification: Two Grades C and Grade D; (2) Summary of the Peer-Review Report: This manuscript reported a case of herpes zoster radiculopathy accompanying severe motor weakness. Electrodiagnostic study is used in this case to help diagnose and follow-up the recovery. The authors mentioned that clinicians should consider the possibility of post-herpetic paresis, such as herpes zoster radiculopathy, which can be identified and monitored by the electrodiagnostic study. This is an interesting case, and the manuscript is well organized. The questions raised by the reviewers should be answered; and (3) Format: There are 3 tables and 2 figures. A total of 9 references are cited, including 1 reference published in the last 3 years. There are no self-citations. 2 Language evaluation: Classification: Three Grades B. A language editing certificate issued by eWorldEditing was provided. 3 Academic norms and rules: The authors provided the written informed consent. No academic misconduct was found in the Bing search. 4 Supplementary comments: This is an unsolicited manuscript. No financial support was obtained for the study. The topic has not previously been published in the WJCC. 5 Issues raised: (1) The authors did not provide original pictures. Please provide the original figure documents. Please prepare and arrange the figures using PowerPoint to ensure that all graphs or arrows or text portions can be reprocessed by the editor; and (2) Authors should always cite references that are relevant to their study. Please check and remove any references that not relevant to this study. 6 Recommendation: Conditional acceptance.

Author response: We appreciate the suggestions and agree with the editor's opinion. We will provide figures using PowerPoint. Moreover, we removed two references that were not relevant to this study, and added seven references strengthening this manuscript.

ROUND 2

Specific Comments To Authors: MS reference: 62450 Title: Complete Recovery of Herpes Zoster Radiculopathy Based on an Electrodiagnostic Study: A Case Report 1. Major comment: The authors have answered my questions carefully and made appropriate amendments to related comments. One remaining concern is that whether this report is exactly "the first case report of complete recovery of herpes zoster radiculopathy demonstrated on electrodiagnostic study" (as has been mentioned by the authors in the manuscript)? According to the literature and the references cited by the authors, some case series of segmental zoster paresis of limbs have been published and completely recovery of such patients have been described. For example, in the paper published by Liu et al., the #1 Patient regained the full arm strength without any treatments within 3 months follow-up period (electrophysiological results were provided). References: 14. Liu Y, Wu BY, Ma ZS, Xu JJ, Yang B, Li H, et al., A retrospective case series of segmental zoster paresis of limbs: clinical, electrophysiological and imaging characteristics. BMC Neurology, 2018;18(1): 121 [PMID: 30131076 DOI: 10.1186/s12883-018-1130-4] 2. Minor comment: In the previous comments, I pointed out some inconsistencies in the format (whether "th" is superscript or not), but this does not mean that the superscript format is wrong. It is recommended to refer to the specific requirements of the journal. Sincerely.

We appreciate the reviewer and absolutely agree that we had a mistake. We appreciate to the reviewer's comment and agree that the following sentence should be deleted: "The feature distinguishing this study from previous studies is that we confirmed complete recovery via follow-up electrodiagnostic study. To the best of our knowledge, this is the first case report of complete recovery of herpes zoster radiculopathy demonstrated on electrodiagnostic study.." on page 9, lines 249-252. We hope that this change address your concerns and make the manuscript suitable for publication in the World Journal of Clinical Cases. Thank you for your

consideration. Sincerely.