Dear editor and reviewers,

I am glad to receive your email notification for revision to my manuscript No:73961. Thanks for the comments of two reviewers, which are pertinent and reasonable. I have revised and uploaded my manuscript to F6Publishing. Please re-review and let me know if there are any additional issues. Thank you!

According to the first reviewer's comments, I have checked over the manuscript and revised the incorrect syntax, informal words, and typographic errors.

I am trying to address the second reviewer's issues. Issue 1, Histopathology of the lesion tissues displayed the characteristics of chronic osteomyelitis on HE staining, however, fungal spores were not examined for lack of specific stain at that time, so pathologist reported chronic osteomyelitis. The word "suppurative" should be a mistaken translation, which I have deleted in revised manuscript. Issue 2, We speculated that cryptococcus osteomyelitis in the patient probably originated from hematogenous dissemination, based on 1) local swelling prior to skin ulceration and sinus formation, 2) multiple non-contiguous osteolytic lesions in the ulna, and 3) no history of direct repetitive trauma at the local infected site. Nevertheless, we could not entirely exclude the possibility of direct inoculation, as the reviewer has pointed, the high CRP but negative crptococcal antigen in blood did not fully support typical hematogenous dissemination. Issue 3, For better antifungal effect early treatment upgraded from fluconazole to voriconazole (MIC= 4 for fluconazole vs MIC≦0.125 for voriconazole). One month later fluconazole was prescribed back in clinic in consideration of the patient's economic condition and obviously decreased value of blood inflammatory markers. Antifungal fluconazole still worked as the inflammatory markers continued to decline on regular follow-ups. Fluconazole was still necessary unless the inflammatory marker had returned to normal and the lesions had disappeared on radiograph. We did not know exactly why the patient carry a cryptococcal strain with higher MIC to fluconazole. We assumed this may result from the long routine use of fluconazole to treat crptococcal infections in her residential district, although the patient had never received such antifungal treatment before.

With best regards,
Fuchun Yang