

Reviewer 1		
The reviewers comments are very well taken and we have tried to modified the manuscript accordingly as per reviewers suggestions		
<p>The present report described a case report of a disseminated cryptosporidiosis caused by <i>C. hominis</i>. PCR was done for identification of the parasite and treatment protocol was followed. The following modifications are needed</p> <ol style="list-style-type: none"> 1) There is no need for the obvious facts such as figure 1 and amplification of genes in figure 2 and 4. 2) An important part of the discussion must have been the patients response to treatment protocol. Not much is discussed. I believe more is needed for such discussion 3) At the end paper can be presented as a short communication 	<p>Treatment has been added in the discussion</p> <p>Gel pictures have been removed</p>	<p>Line no. 218-224</p> <p>Treatment has been added in discussion Line no. 218-224</p>
Reviewer 2		
<p>Interesting report. But several weaknesses should be address: Major concern: The underlying diagnosis of CD8 deficiency should be clarified: There are only two reports of CD8a deficiency -includes ABSENT CD8 cells- (one group in Paris and one in Madrid). I have the opportunity to follow one of these patients and we should keep in mind that CD8a is somewhat redundant for adaptative immunity. None of the patients with CD8a deficiency suffered from crypto infections. The authors should support their diagnosis with proper flow cytometry data, including CD+, CD19 and CD3-/56+ or 16+ staining. Are IgG levels available? It could be great if they ruled out CD40L as these patients are specially prone to crypto infection (and a major cause of death - manuscript submitted-) and neutropenia is found in 25% of CD40L deficient patients. Decreased CD8+ lymph count may be encountered in atypical severe combined immunodeficiency or combined immunodeficiency. Thus, a normal CD3+CD4+CD45RA+ (or specifically CD31+ also called recent thymic emigrant) is the only way to discard a T-cell deficiency. In case of normal immunoglobulin levels</p>	<p>Immunological profile has been added in the case report</p> <p>CD3+, CD4+ and CD8+ data has been added in figure 1</p> <p>Chest X ray has been added in figure 2</p> <p>Typographical errors have been corrected</p> <p>Co-trimoxazole prophylaxis dose revised</p>	<p>Line no. 104-105</p> <p>Line no. 145, 120, 138 and 136</p> <p>Line no. 108</p>

<p>CD40L may be reasonably discarded. Could necropsy be performed? Minor concerns: 1. The patient initially received Co-trimoxazole (4 ml OD) and then was increased. I encourage the authors to specify the doses in mg/m² 2. Typo mistakes: Fluconazole, infiltrates, PCP (better PJ), "Child showed no signs of improvement died", 3. It could be more illustrative if a chest x-ray is included showing the lung infection.</p>		
<p>Reviewer 3</p>		
<p>The manuscript by Khalil et al. Reported a case of respiratory and intestinal cryptosporidiosis in a child with CD8+ T-cell population deficiency. The manuscript is well described and contains important information. I just comment some minor points.</p>		
<p>Reviewer 4</p>		
<p>It is a well written case report describing a 15 months old child with CD8+ immunodeficiency, suffering from disseminated Cryptosporidiosis leading to death. Review of Cryptosporidiosis infections in immunocompetent and immunocompromized children, with emphasis on respiratory involvement, was conducted. Few comments: 1. Abstract: Please add the age of the patient. 2. Introduction: Please add the incidence and geographical variation of <i>Cryptosporidium</i> infection in children. 3. Case report: How disseminated CMV infection has been diagnosed (PCR or viral culture of CMV from urine, saliva, throat swab specimens or other body tissues?). Has CMV infection been eradicated? If yes when a last positive CMV sample was detected in the patient? 4. Case report: Has complete immunology failure investigation been done in the patient? CD8+ deficiency is the only abnormal index from immunology panel? 5. Discussion: Please add treatment options for Cryptosporidiosis infections</p>	<p>Child age has been added in the abstract</p> <p>Incidence of geographical variation of <i>cryptosporidium</i> in children has been added to introduction</p> <p>Patient was positive for PCP by conventional PCR using blood sample.</p> <p>The CMV infection was eradicated and patient was negative CMV at the time of this hospital admission</p> <p>Treatment options for <i>Cryptosporidium</i> has been added</p>	<p>Line no. 28-29</p> <p>Line no. 53-60</p> <p>Line no. 218-224</p>

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