TO THE EDITOR

We have read the opinions of the two reviewers carefully, and are grateful for the questions raised by the reviewers. According to the opinion, the corresponding parts have been improved. And the response to the questions raised by the reviewers is as follows:

First of all, the parts that need to be modified have been carefully revised. In order to meet the writing requirements, a native-English speaker has edited the manuscript, and we have uploaded the Non-Native speakers of English Editing Certification to the editorial office. The parts of Core tip and Conclusion have been simplified and improved.

The “Patient population” in this article refers to immunosuppression people, such as the patients who have solid organ tumors, leukemia, HIV.....

Secondly, although the *Fusarium* is the second most common mold infection in immunosuppression people, the incidence is much lower than that of *Candida* and *Aspergillus* infections. In the immunocompromised patients, disseminated Candida and Aspergillus infections account for the majority. And maybe due to the use of prophylactic anti-fungal drugs, blood culture and GM test of serum samples were negative in this patient. In addition, clinical manifestation of *Fusarium* infection vary considerably. In the early days, it may just show an unrelieved fever, which is a non-specific manifestation, and this needs to be differentiated from other pathogens infection. In many patients, skin lesions maybe the first sign of a disseminated *Fusarium* infection and are commonly seen in the early stages of the disease. Lung involvement is also common in invasive fusariosis and invasive procedures will be necessary.

Thirdly, in the history of presenting illness, we specify the type of ALL and the details about the chemotherapeutic regimen. He was treated with BMF95 chemotherapy regimen (vindesine, daunorubicin, L-aspartase, and prednisone) according to the NCCN（National Comprehensive Cancer Network) guidelines and achieved complete remission (CR). We adjust the narrative of anti-fungal prophylaxis. The patient has a

long time fever and neutropenia, although the blood culture is *Klebsiella pneumoniae*, owing to the high risk of acquiring invasive fungal disease, he also received caspofungin for anti-fungal prophylaxis. When the patient developed skin lesions, we performed skin biopsy and microbial culture. The result support *Fusarium* spp infection, then the patient started the treatment of voriconazole and liposomal AmB. We added the figures of microscopic examination result, including Fluorescence microscopy. In the course of anti-fungal therapy, there was not any change in the anti-fungal agents. The patient developed a rapidly disseminated infection, we think there are two reasons. First, it has been reported that the *Fusarium* is easy to invade the vascular epithelium, and occurs a rapidly disseminated infection. Second, owing to the particular structure and slender blood vessels in eyeball and joint, the effective drug treatment concentration may not be achieved. It also proved the value of surgical debridement and the use of topical antifungal agents.

At last, we added the high risk factors in this patient for fusariosis. And when these factors are present, clinical works also need to be alert to other pathogens infection. In the part of discussion, we concluded the fungal sepsis observed in ALL patients (most common organisms, clinical features, treatment modalities), including Candida、Aspergillus、Mucor infections.