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PEER-REVIEW REPORT

Name of journal: World Journal of Transplantation
Manuscript NO: 33156
Title: Histopathological analysis of infiltrating T cell subsets in acute T cell-mediated rejection in the kidney transplant
Reviewer's code: 00503228
Reviewer's country: Iran
Science editor: Fang-Fang Ji
Date sent for review: 2017-03-25
Date reviewed: 2017-04-06

CLASSIFICATION	LANGUAGE EVALUATION	SCIENTIFIC MISCONDUCT	CONCLUSION
[ ] Grade A: Excellent	[Y] Grade A: Priority publishing	Google Search:	[ ] Accept
[ ] Grade B: Very good	[ ] Grade B: Minor language polishing	[ ] The same title	[ ] High priority for publication
[Y] Grade C: Good	[ ] Grade C: A great deal of language polishing	[ ] Duplicate publication	[ ] Rejection
[ ] Grade D: Fair	[ ] Grade D: Rejected	[ ] Plagiarism	[ ] Minor revision
[ ] Grade E: Poor		[Y] No	[Y] Major revision
		BPG Search:	
		[ ] The same title	
		[ ] Duplicate publication	
		[ ] Plagiarism	
		[Y] No	

COMMENTS TO AUTHORS

Methods: you should have controlled your case and control patients by age, transplant vintage, immunosuppression (tacrolimus, cyclosporine, monoclonal antibodies); most important factors. Fatal limitation! Results: Results: - Were all the rejection episodes the first one in the patients, and if the non-rejection patients had any rejection episodes in their history? - due to the limited sample size, I recommend you to give a table representing all 21 cases one by one with detailed data (including Fuggle's immune risk, HLA mismatches, immunohistochmy results, rejectionand so forth) - Why then the initial IS regimen were different between the groups? - "a few ATCMR-KTx patients had higher infiltration by granzyme B+ and Foxp3+ cells" OK, what was its significance then? how it affected the outcome results? - "...This suggests that in ATCMR-KTx patients Foxp3+ Treg cells might be overwhelmed" this is not a thing that should be brought in the results, but the discussion section. - You say in either rejection and non-rejection groups, the number of type 17 helper T (Th17) cells are associated with worse outcome

(serum creatinine and other outcome). It is expected because we know that Th17 cells can mediate glucocorticoid-resistant rejection. Please discuss this in the discussion, if this may mean that some of the non-rejection patients of yours detected by the current criteria, might have been diagnosed as rejection patients and treated with intensive immunosuppressives? Especially considering the observation of the ratio of Th17 cells over Foxp3+ Treg cells in the "non-rejection patients" were significantly positively correlated with the outcome, while you know Foxp3 cells have been suggested to be protective against rejections.