Reviewer 1

1. However, the text needs improvement, and the wording should be comprehensively reviewed, preferably by a native English-speaking professional.

Thank you for your comments. We submit the manuscript to a professional English editing company for polishing and obtain their editing certificate.

2. Consider include more Figures, divided in 1, 2, 3. The images presented are too small.

Thank you for your comments. We have enlarged and re-labeled the image, as Figure 3-5.

3. Cerebellar edema and brain hernia (Ascending transtentorial herniation?)

Thank you for your comments. We have indicated the lesion site with a red arrow on the Figure 3-5.

4. MRI scan showed suspicious T2: REMOVE suspicious.

Thank you for your comments. We have removed the "suspicious".

5. Acute disseminated encephalomyelitis (ADEM), also named post-infectious encephalomyelitis and immune-mediated encephalomyelitis, could be considered.

Thank you for your comments. We reviewed the literature you recommended, and the reasons for excluding ADEM are as follow:

Differential diagnosis of ADEM:

(1)Clinical symptom: the child was admitted to the hospital for more than 40 days, with ataxia, ptosis, eye movement disorder and other brain stem and cerebellar symptoms, but the head MRI did not show any abnormalities. So the clinical symptoms and imaging changes were inconsistent, which do not support the diagnosis of ADEM.

(2)Physical examination: the child had clinical symptoms of myasthenia and white matter lesions in spinal cord MRI, but physical examination revealed hypotonia which is not consistent with the changes of upper motor neurons in spinal cord lesions of ADEM.

(3) Course of diseases: although the child had a history of rabies vaccination 2 months before admission, he had a history of paroxysmic convulsions 3 months and 50 days before admission, and then he was admitted to the hospital due to walking instability and ptosis for more than 40 days. Respiratory failure occurred less than a week after admission. It was not consistent with the course of conventional ADEM immune disease, but more consistent with the course of metabolic disease.

(4)Treatment: clinically, most ADEM patients are sensitive to glucocorticoid therapy and have a good therapeutic effect. A small number of hemorrhagic necrotizing encephalomyelitis patients have a poor prognosis. However, the patient still progressed after active immunotherapy, which does not support the diagnosis of ADEM.

Reviewer 2

1. Interesting paper. Major revision. B for all the answers regarding relevance of topic. Very good Authors should investigate other causes of the edema。

Thank you for your comments. Brain CT angiography showed that the straight sinus was not clear, and vascular infarction could not be excluded at that time.
Brain CT before admission and brain MRI after admission were normal.Due to the abnormality of the spinal cord MRI, the immune etiology could not be excluded. According to the clinical diagnosis and treatment idea, the effect of hormone and gamma globulin was not good, and active plasma exchange treatment was given. On the second day of plasma exchange, the pupil was dilated, and cerebral hemorrhage was suspected at that time. Brain CT showed cerebellar edema, and the D-dimer was high. Therefore, it could not be excluded that cerebellar edema was caused by obstruction of venous return caused by straight sinus infarction during plasma exchange. However, the evidence is not sufficient, the relatively common clinical complication of plasma exchange is bleeding, and the exchange time is very short, only 2 hours, the process is very smooth, the coagulation function of the child before the exchange is normal, so the possibility of vascular infarction is very small, and the unclear straight sinus may also be caused by primary cerebellar edema.