## Review Form 1.6

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| Journal Name: | **International Journal of TROPICAL DISEASE & Health** |
| Manuscript Number: | **Ms_IJTDH_79775** |
| Title of the Manuscript: | **Prevalence of Dermatophytosis in patients attending a Research hospital for Skin Disorders in Hyderabad, South India** |
| Type of the Article | **Original Research Article** |

**General guideline for Peer Review process:**

This journal's peer review policy states that **NO** manuscript should be rejected only on the basis of '**lack of Novelty'**, provided the manuscript is scientifically robust and technically sound.
To know the complete guideline for Peer Review process, reviewers are requested to visit this link:

(https://www.journalijtdh.com/index.php/IJTDH/editorial-policy )

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**PART 1: Review Comments**

| | **Reviewer's comment** | **Author's comment** *(if agreed with reviewer, correct the manuscript and highlight that part in the manuscript. It is mandatory that authors should write his/her feedback here)* |
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| **Compulsory** REVISION comments | - Interesting manuscript.<br>- Authors mentioned that patient with clinical suspect of tinea underwent the KOH test and then of those tested, only 78% had a positive test. Please clarify the following. The 22% difference observed between clinical suspect and KOH diagnosis is attributed to what?<br>  ○ Is it over diagnosis (i.e. patient were diagnosed by tinea by mistake but the diagnosis was in fact something else? Did you notice that high number of patients results turned negative because of one or two referring physician? I mean were these doctors over diagnosing tinea)? Is it due to improper scraping (e.g. did you notice that negative results were commoner in the scrapping done by one or two physicians)?<br>  ○ Or is it to reduced test sensitivity? Like if the test turned out to be negative and the patient was empirically started on antifungal, did the lesion improve or persist? Did you run any further test after a negative results? May be a culture?<br>- Figure 1 is a replication of information already presented in Table 3. I would suggest you follow on the following options:<br>  ○ You either keep table 3 and delete figure 1; OR<br>  ○ Delete both, Table 3 and Figure 1 and you represent the data in Table 3 using stacked columns (i.e. one column id for each subtype of tinea, and in each column the patients' sex would appear stacked on each other | |
| **Minor** REVISION comments | | |
| **Optional/General** comments | - Table 4 would appear more appealing if presented in stacked columns as well.<br>- I understand that you have already mentioned this point in the discussion section, but it would be a good idea if you were able to explain (with evidence) the differences in prevalence of tinea across males and females and in different ages in your patients. This would be possible by may be referring to personal causes (e.g. comorbidities like diabetes mellitus) or environmental causes (e.g. being in contact with animals) in your patients.<br>- In a developing country, is it more feasible to empirically treat tinea or to diagnose and treat? In our country, we usually treat patients first and we don't go for KOH or culture and sensitivity unless the case was resistant to treatment or the presentation was untypical.<br>- Manuscript was written in understandable language, however it still needs English proofreading for further refinement. | |

## Review Form 1.6

**PART 2:**

| | **Reviewer's comment** | **Author's comment** *(if agreed with reviewer, correct the manuscript and highlight that part in the manuscript. It is mandatory that authors should write his/her feedback here)* |
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| **Are there ethical issues in this manuscript?** | *(If yes, Kindly please write down the ethical issues here in details)* | |

**Reviewer Details:**

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|---|---|
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