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| Journal Name: | [**International Journal of Advances in Nephrology Research**](https://journalijanr.com/index.php/IJANR) |
| Manuscript Number: | **Ms\_IJANR\_132635** |
| Title of the Manuscript: | **Unveiling Rapidly Progressive Glomerulonephritis (RPGN) in Females: A Retrospective Analysis of Trends and Outcomes in Northwest Rajasthan** |
| Type of the Article | **Original Research Article** |

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| PART 1: Comments | | |
|  | Reviewer’s comment **Artificial Intelligence (AI) generated or assisted review comments are strictly prohibited during peer review.** | Author’s Feedback *(Please correct the manuscript and highlight that part in the manuscript. It is mandatory that authors should write his/her feedback here)* |
| **Please write a few sentences regarding the importance of this manuscript for the scientific community. A minimum of 3-4 sentences may be required for this part.** | This study highlights the epidemiology, histopathology and outcome of RPGN in female patients from Northwest Rajasthan, addressing the limited availability of region-specific data. Early and accurate diagnosis is crucial for improving patient outcomes, with a renal biopsy being the cornerstone for definitive diagnosis. Serologic tests, including ANCA, anti-GBM, and ANA, should complement the biopsy findings to establish the underlying etiology. A prompt kidney biopsy allows timely classification of RPGN subtypes, guiding appropriate treatment strategies. In severe cases, empiric therapy may be initiated while awaiting biopsy results to prevent irreversible renal damage. Early diagnosis and intervention significantly reduce the risk of ESRD progression and overall survival. | Rapidly progressive glomerulonephritis (RPGN) is a clinical syndrome characterized by a rapid decline in kidney function ie 50% reduction in glomerular filtration rate over three months, accompanied by oliguria or anuria and features of glomerulonephritis ,including dysmorphic erythrocyturia ,erythrocyte cylindruria, and glomerular proteinuria .This aggressive pathology results from glomerular capillary rupture promoting inflammatory cell infiltration and if not treated timely and aggressively leads to end stage renal disease. To improve outcomes in a patient with a rapidly progressive glomerulonephritis presentation, early referral to a nephrologist for prompt diagnosis and treatment is crucial for both renal and patient survival. |
| **Is the title of the article suitable?**  **(If not please suggest an alternative title)** | The title appears automated and could be refined for better clarity and professionalism. An alternative suggestion: "Rapidly Progressive Glomerulonephritis in Women: Clinical and Histopathological Trends in Northwest Rajasthan.” | Rapidly Progressive Glomerulonephritis in Women: Clinical and Histopathological Trends in Northwest Rajasthan. |
| Is the abstract of the article comprehensive? Do you suggest the addition (or deletion) of some points in this section? Please write your suggestions here. | The abstract is well-structured and provides a clear summary of the study. However, specifying the treatment modality and follow-up duration would enhance clarity. | Depending on the type of RPGN and overall clinical status, the patients were treated for the disease as per standard protocol. in type I RPGN, patients were treated with 3 doses pulse steroid (500 mg each ) and oral steroids ( 1 mg/kg/day tapered to 20 mg/ day by 6 weeks) for 6 months along with oral cyclophosphamide 2.5 mg/ kg / day for 12 weeks and plasmapheresis with 50 ml/kg volume exchange with 5% albumin if patient had alveolar hemorrhage, non oliguric disease or creatinine less than 5.7 mg /dl. No maintenance therapy is needed for anti GBM disease. In Anti GBM plus Anca disease ( type IV RPGN ) patient are treated with maintenance therapy as per ANCA disease .In type II RPGN, Patients were started on induction therapy with three methylprednisolone (0.5 g) pulses followed by oral prednisolone plus six intravenous cyclophosphamide fortnightly pulses (500 mg each). After induction phase, patients were started on maintenance therapy with mycophenolate mofetil ( 2gm/ day) in lupus nephritis.In type III RPGN, patients were given induction with iv cyclophosphamide (15mg/kg) every two weeks for three doses followed by every 3 weeks for another three doses followed by maintenance with azathioprine ( 1-1.5 mg/ kg/ day.) Those patients that do not showed improvement in 8-12 weeks were withdrawn from immunosuppression.Patients were followed up for a period of twelve months. Complete blood counts, serum creatinine, blood urea nitrogen, urine routine examination, and 24 h urine protein or spot urine to protein creatinine ratio were done according to predefined intervals. |
| Is the manuscript scientifically, correct? Please write here. | Yes, the study design scientifically addresses the research question. The RPGN classification system is well-defined and follows international standards. The statistical analysis is detailed, but providing more clarity on multivariate regression would strengthen the findings | ok |
| **Are the references sufficient and recent? If you have suggestions of additional references, please mention them in the review form.** | The references are sufficient and mostly recent | ok |
| Is the language/English quality of the article suitable for scholarly communications? | There are minor grammatical errors throughout the manuscript. To enhance the professionalism and readability of the text, careful language refinement is required. The use of English language editing software or assistance from a colleague proficient in academic writing is recommended to ensure grammatical accuracy and clarity. | ok |
| Optional/General comments | Consider expanding the discussion by providing additional details on the treatment strategies for RPGN, including the role of corticosteroids, cyclophosphamide, plasmapheresis, and rituximab, in alignment with current guidelines. Furthermore, conducting a multivariate regression analysis to determine whether congestive heart failure, respiratory infections, and diabetes mellitus were independent risk factors for mortality and ESRD progression would strengthen the study’s conclusions. Including these analyses would enhance the manuscript’s clinical relevance and provide deeper insights into patient prognosi  Let me take this opportunity to congratulate you for your genuine work and appreciate your efforts for the same !  I would like to suggest you some changes in your article -   1. Grammar needs to be polished throughout the manuscript 2. Provide a detailed explanation of the protocol followed for treating RPGN and the follow-up strategies in the Introduction and Discussion sections. 3. Table 2 in the manuscript are excessively long and may affect readability. Consider splitting them into smaller, well-organized tables or presenting key findings in summarized formats to enhance clarity and comprehension. 4. In the abstract, briefly mention the statistical methods used and key findings on treatment impact and survival outcomes 5. Kindly include key socio-demographic data, such as diet, religion, type of residence (rural/urban), and the mean age in the mortality, ESRD, and non-ESRD groups 6. The study's limitations should also include the retrospective design, small sample size, single-center data, and potential selection bias. 7. Conducting a multivariate regression analysis is recommended to determine whether heart failure, respiratory infections, and diabetes mellitus were independent risk factors for mortality and ESRD. 8. The discussion should highlight independent predictors of ESRD and mortality, such as IFTA, serum creatinine at presentation, and the need for hemodialysis, supported by statistical validation. 9. A statement regarding informed consent and competing interests should be explicitly mentioned in the manuscript 10. Authors should include in the conclusion section “the need for prospective multicenter studies, incorporation of socio-demographic data, use of multivariate analysis to identify independent risk factors, and long-term follow-up to assess treatment efficacy across RPGN subtypes.” | Depending on the type of RPGN and overall clinical status, the patients were treated for the disease as per standard protocol. in type I RPGN, patients were treated with 3 doses pulse steroid (500 mg each) and oral steroids (1 mg/kg/day tapered to 20 mg/ day by 6 weeks) for 6 months along with oral cyclophosphamide 2.5 mg/ kg / day for 12 weeks and plasmapheresis with 50 ml/kg volume exchange with 5% albumin if patient had alveolar hemorrhage, non oliguric disease or creatinine less than 5.7 mg /dl. No maintenance therapy is needed for anti GBM disease. In Anti GBM plus Anca disease (type IV RPGN) patient are treated with maintenance therapy as per ANCA disease.    In type II RPGN, Patients were started on induction therapy with three methylprednisolone (0.5 g) pulses followed by oral prednisolone plus six intravenous cyclophosphamide fortnightly pulses (500 mg each). After induction phase, patients were started on maintenance therapy with mycophenolate mofetil (2 gm/ day) in lupus nephritis.  In type III RPGN, patients were given induction with iv cyclophosphamide (15mg/kg) every two weeks for three doses followed by every 3 weeks for another three doses followed by maintenance with azathioprine (1-1.5 mg/ kg/ day.) Those patients that do not showed improvement in 8-12 weeks were withdrawn from immunosuppression.  Limitations of the study include retrospective study ., short follow up of one year, single centre study.  MENTIONED  “the need for prospective multicenter studies, incorporation of socio-demographic data, use of multivariate analysis to identify independent risk factors, and long-term follow-up to assess treatment efficacy across RPGN subtypes. |

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| **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)* |
| **Are there ethical issues in this manuscript?** | *(If yes, Kindly please write down the ethical issues here in details)* |  |