**Reviewer Comments to Author:**

**Reviewer1:** ( biostatistician)

Tables contain many mistakes that make me feel that it is fabricated data, as online calculation of some data yields different results. Correlation tables appear manufactured as r and p do not match. Results lack posthoc analysis, revision of some false p-value, reversal of incorrect p-value interpretation, adding p-value for mortality, and clarifying the type of data represented either mean, SD or median and IQR.

Results contain many mistakes that need statistician consultation. Some tables have false p values. Correlation tables are wrong both r and corresponding p do not match.

Please attach your dataset for revision after doing the necessary modifications.

The footnote of tables should contain the meaning of abbreviations and the significance test used to calculate p.

Posthoc tests should be added for each essential data.

Check the uploaded file.

**All notes were corrected.**

**Reviewer 2:**

1. I need an explanation why mild cases and asymptomatic cases were hospitalized

**As they were worried about their COVID, also some of them were HCV +ve, and others were cirrhotics**

1. Data from Laboratory investigations conducted at the time of admission need to be corrected.

**corrected**

1. Table 3 shows how ALT is expressed as mean and SD while abnormally distributed and needs to be corrected statistically.

**corrected**

**Reviewer 3:**

1.‎ ‎ Page ( 3 ) line (58), which wave of the COVID pandemic?‎

**wave in 2022**

‎2.‎ Page (3) line (60) what is the IRB number and date?‎

**Ok, I will add**

‎3.‎ ‎ Page ( 3 ) line (‎‏ 65 ‏‎), all patients have HCV positive or group II -III. What ‎about CLD patients with another etiology?‎

**We included only HCV +ve**

‎4.‎ Page (4) line (‎‏ 68 ‏‎) were mild cases admitted? ‎

**some of them were mild**

‎5.‎ Page (4) line (‎‏ ‏‎75‎‏ ‏‎) medications of 3 groups the same?‎

**Yes**

‎6.‎ Page (5) line (‎‏ ‏‎101‎‏ ‏‎) reference of COVID severity classifications?‎

Added **(Hegazy et al.,2021).**

**Hegazy N, Alashwal H and Ibrahim S (2021).** Association of hypertension, diabetes, stroke, cancer, kidney disease, and high- cholesterol with COVID-19 disease severity and fatality: A systematic review. Diabetes & Metabolic Syndrome: Clinical Research & Reviews, 14, 1133-1142.

‎7.‎ Page (6) line (‎‏ ‏‎136‎‏ ‏‎) causes of admission and hospitalization of ‎asymptomatic patients? how severe COVID asymptomatic?‎

**I added hospitalization criteria**

**‎**8.‎ Page (7) line (‎‏ ‏‎‏138 ‏‎‏ ‏‎) and table 2, 16.6 % of chronic hepatitis had HE. I ‎think DLOC is due to another cause.‎

**chest problems may be a precipitating factor for HE**

**Reviewer 4:**

Grammar corrections are needed.

**done**

**Reviewer 5:**

1. on Page6.There are no results for the concomitant illnesses: heart disease, connective tissue disease, and hyperlipidemia in table1.

**We included only common chronic diseases.**

1. Page7 and table2.How come the number of patients with cough is 30, asymptomatic cases are 8 in G1, while the total number of cases in each group is 36?

modified

1. Also, G2: patients with fever=30, asymptomatic cases=7, while the total number of cases in each group=36.

**modified**

1. -do you admit asymptomatic cases to isolation hospitals?

**Due to comorbidity or waiting for surgery**

1. - in Page7 Table 3. sodium, potassium, magnesium, and calcium are mentioned in the text on page 7, while there are no values for these parameters in table 3.

**modified**

1. in Page7 and table4.A percentage of patients with ascites (72.2 %) was mentioned on page 7, while there are no values regarding ascites in table 4.

**Already present**

1. on Page6 and table 1. HCC is written as an abbreviation only.

**modified**

1. in Page 7, Table 3. Measurement units for the lab. Parameters are not mentioned either in the text or in table3.

**Units used were used in our hospital.**

1. What is the novel research point in your study?

**Impact of chronic liver disease on COVID-19 infection at Zagazig University Hospitals**

1. It was already proven that liver disease or dysfunction increases the severity of COVID‐19 and that COVID‐19 aggravates liver decompensation in ref. 10,14,18.

**It was our study at ZUH.**

**Reviewer 6:**

**1. editing of English language and style is required.:** done

**2. introduction, explain the link between covid and liver pathophysiology.**

Already present: Chronic liver disease (CLD) is linked to immune system failure, which increases the risk of infections and consequences brought on by COVID-19

the SARS-CoV-2 infection causes abnormal liver tests in the general population, including elevated levels of the alanine-transaminase (ALT) and aspartate-transaminase (AST), total bilirubin, and prothrombin time (PT)

also, I added IL-2 and IL-17A had been suggested to be key inflammatory factors causing liver injury in COVID-19 patients. The early increase in AST level and its correlation with disease severity indicate that immune-mediated inflammation plays an important role in liver injury in severe COVID-19 patients (Zhou et al.,2021)

**Zhou, F., Xia, J., Yuan, H. X., Sun, Y., & Zhang, Y. (2021). Liver injury in COVID-19: Known and unknown. World Journal of Clinical Cases, 9(19), 4980.**

**3. In inclusion and exclusion criteria, what about combined infection as HBV.:** HCV +ve only were included. Combined infection were excluded

**4. study design, what about the history of DAA use? It would be best if you mentioned the zagazig hospitalization criteria.**

All patients received DAA according to the Egyptian campaign

Zag Hospitaliz criteria:

+ve COVID-19 PCR in nasopharyngeal swab and +ve CT chest findings in covid patients with dyspnea and oxygen saturation below 90.

Also, patients with comorbid conditions or emergency cases requiring hospital admission and were discovered to be +ve COVID-19 PCR in nasopharyngeal swab

**5. result**

**a.identify CT finding and its grades**

CT scanning in patients with COVID-19–associated pneumonia usually shows ground-glass opacification, possibly with consolidation.

Some studies have reported that abnormalities on chest CT scans are usually bilateral, involve the lower lobes, and have a peripheral distribution. Pleural effusion, pleural thickening, and lymphadenopathy have also been reported, although with less frequency (Ojha et al., 2020).

Ojha V, Mani A, Pandey NN et al. (2020). CT in coronavirus disease 2019 (COVID-19): a systematic review of chest CT findings in 4410 adult patients. European radiology, 30, 6129-6138.

COVID working group of the Dutch Radiological Society. CO-RADS classification. https://radiologyassistant.nl/

chest/covid-19-CORADS-classification

**b. Table 1. HCC in chronic C hepatitis...?**

**HCC was more common in cirrhotic patients (group III). However, it was found in this study ..**  removed

**Table 2 .. explains the cause of hepatic encephalopathy in chronic hepatitis. This is decompensation as group 3**

COVID-19 infection leads to acute decompensation in these patients, and in group II patients, there were minimal symptoms such as altered behavior and astrexis

**Table 4... Identify CT finding:** CO-RADS 4 and 5

**Table 5 in group 3 only:**

Yes, as group II was child A

**Editor Comments to Author:**

1. Please check the author names and affiliations included on your Title Page, mainly that the spelling of all authors' names is correct. They are cited in the order you wish them to appear in the final article. In addition, each author's affiliation details are correct.

2. Please include a 'Structured Abstract': not more than 250 words, broken down into, i.e., Aims, Patients & Methods/Materials & Methods, Results, and Conclusions. For authors presenting the results of clinical trials, the guidelines recommended by CONSORT should be followed when writing the abstract (http://www.consort-statement.org/), and the clinical trial registration number should be included at the end of the abstract, where available.

3. Please include up to 10 keywords in your revised manuscript (including the four keywords you selected as part of the submission process).

4. Please amend the references as per the author's guidelines:

a. References should be numerically listed in the reference section in the order in which they occur in the text.

b. References should appear as a number, i.e., [1, 2] in the text.

c. References should cite three authors et al.: it is our house style to list a maximum of six authors, and if there is more than this, three authors et al.

5. Please ensure that all tables and boxes are titled and cited in the text.

Please find a link to the African Journal of gastroenterology and hepatology Author Guidelines which explains these sections in more detail: <https://ajgh.journals.ekb.eg/journal/authors.note>.

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7. Please add the scale bar, annotations, magnifications, and program that generated these figures. Also, it is better to submit figures with high resolution and brightness.