Dear Editors:

Thanks for your technical comments. Firstly I really thanks for Prof. Elena Castellano's suggestion about learn from Madeo's STUDY. I don't know if it is a coincidence or there are some other reasons, in both of our study the best cutpoint of Ca/P ratio is 2.71. Clinically, some patients with very low vitaminD level would not have a elevated PTH (especially in diabetes), but sometimes patients with a mild vitaminD deficiency would combined elevated PTH. The amount of body fatty can influence the vitaminD distribution, and the balance between PTH and vitaminD may be different in different ages. I agree with the opinion that the index would lose its predictive value when faced to severe vitaminD deficit. We have added the normal values range in table 1, and compared (Ca/P) Ratio in our study.
This study is a retrospective clinical study, it has some limitations indeedly. It is difficult to design as RCTs, we have made inclusion and exclusion criterias. Is it really difficult to distinguish between D-deficiency SHPT and PHPT, I think this depends on situations, if the patients with some classic symptoms it would be easy, with more and more patients with osteoporosis, the lab tests number of PTH, 25(OH)D, calcium are increase, sometimes we need cheap clinical methods to help clinician make decide, examinations such as MIBI, CT should be arrange for people with a higher level of Pfinde. I agree with the opinion that this tool can not use in kids. We had changed the PTH pg/ml, 25OHD ng/dl, and we have added a graph showing the range of PF index values for the PHPT, NPHPT, SHPT, and control groups.

Thanks for all of your wisdom comments again!