Author's response to reviews

Title: Posterior Migration of Ahmed Glaucoma Valve tube in a patient with Reiger Anomaly: A Case Report

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Author's response to reviews: see over
To
The Editor-in-Chief
BioMed Central

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Dear Sir/ Ma’am,

I first take this opportunity to pass warm greetings and wishes for the New Year from the Department of Ophthalmology, Safdarjung Hospital, New Delhi, India.

Authors here provide revisions to the original case report as per reviewer feedback. Hope the authors are able to live up to the expectations of the peer staff.

Point by Point response to feedback by reviewer 1 is as under:

Major compulsory revisions:

a. We cannot ascribe to the concept of Reiger’s anomaly with segmental zonular dehiscence leading to phacodenesis under such clinical presentation for this particular patient. Authors need to cite other case report/reports linking the two features; otherwise Reiger’s anomaly cannot be solely attributed to this individual patient.

Case report from India has been published in Journal of Pediatric Ophthalmology and Strabismus 2007, reporting association of reiger anomaly with Familial Ectopia Lentis. Hence association of phacodonesis with segmental zonular absence, as may be put more correctly, can be identified. However, a possibility of trauma, incidently unrevealed in the Indian setting or considered trivial, leading to lens subluxation cannot be ruled out.


b. Authors report that they performed trabeculectomy with AGV. They should instead state that they performed aqueous shunt implantation with AGV (TM). It seems no filtering procedure was performed for this patient i.e. no trabeculectomy.

The authors acknowledge the wrong wordings of documenting the performance of trabeculectomy with AGV. It was an incision surgery that was performed with AGV implantation. Relevant corrections have been made in the manuscript.

c. Posterior migration of AGV means that shunt has migrated from anterior to posterior chamber. From anatomical-standpoint then, no posterior capsular touch should be evident.
under such a circumstance. If authors report for such clinical presentation is truly accurate, then they should report that AGV has migrated from anterior chamber to anterior vitreous cavity with posterior capsular touch.
Or are the authors trying to state posterior migration of the AGV from anterior to posterior chamber with ?anterior capsular touch? rather than stating ?posterior capsular touch?? Please clarify.

Authors would like to rephrase the posterior migration of AGV tube, to be anterior to posterior segment migration, with tube end lying in the anterior vitreous cavity; abutting the posterior capsule, with posterior lenticular touch. Relevant corrections have been made in the manuscript.

d. Anatomically we have never heard or seen a report of direct polyurethane material-lenticular touch not causing capsular opacification over time. This is really puzzling particularly if the tube has truly migrated from anterior chamber to anterior vitreous cavity.
Are there any other reported cases of polyurethane/capsular touch in the literature?

Reported cases of various implantable contact lenses/ phakic IOLS exist in literature where cataractous changes are seen to develop over time, in areas of lenticular touch. But what needs to be remembered is that this process occurs at variable rates depending on the material used and also on length of follow-up. No reported case of lenticular touch of AGV tube not causing cataract could be found. We may also remember that length of follow-up in our case is 12 months post-operative, and 6 months after posterior migration was first identified. Course of follow-up may have a different story to tell.

Minor Essential Revisions:
e. Though it may seem at the first glance the introduction and conclusion to be adequate for the literature review, the clinical history of patient needs to be written up in a more concise and polished fashion as well as more detailed and direct pubmed literature review.

The manuscript has been revised and tried to be made more concise.

f. There are multiple spelling errors throughout the text.

Spelling errors have been corrected and rechecked. Authors apologize for such errors.

Response to comments posted by Reviewer 2:

1. The description of surgery is limited and unclear. Why did they decide to perform AGV and trabeculectomy simultaneously? Is the top of the tube was closed with pericardiumor donor sclera? Was the tube secured to sclera with the sutures.
The authors acknowledge the wrong wordings of documenting the performance of trabeculectomy with AGV. It was an incision surgery that was performed with AGV implantation. Manuscript has been revised to document the same, also additions have been made in the description of surgery, stating that the tube was secured with sutures and covered with partial thickness scleral flap. No pericardium/donor sclera was used.

2. Is there any postoperative trauma history of the patient? Figure 1 is not clear enough to locate the position of tube entry. How do you explain the backward movement of the tube without any lens, zonule trauma and cataract formation because length of tube into the anterior chamber is quite long?

There is no definite history of trauma as stated by the patient. However, a possibility of trauma, incidently unrevealed in the Indian setting or considered trivial, leading to lens subluxation cannot be ruled out. Backward movement of tube without any lens/zonular trauma may be explained by the presence of segmental zonular absence and lens subluxation. There is no evidence of cataract formation. This may be exemplified by evidence of use of Phakic posterior chamber IOLs which may abut the lens, yet not cause lenticular changes for a considerable length of time. No reported case of lenticular touch of AGV tube not causing cataract could be found. We may also remember that length of follow-up in our case is 12 months post-operative, and 6 months after posterior migration was first identified. Course of follow-up may have a different story to tell.

3. At least postoperative UBM or anterior segment optical coherence tomography images must be added to verify exact course of the tube.

Keeping the Indian scenario in mind, where cost effective treatment plays a large role, UBM or anterior segment OCT images could not be procured. However, authors acknowledge the definite role of these modalities in verifying the exact course of the tube.

Informed consent for the reporting and publication of case summary and photographs has been taken from the patient. This is the revised version of the manuscript with no prior failed attempts at submission or publication of this article. This manuscript is truly an original work. The authors had full access to all the data incorporated in the article and take full responsibility for the integrity and accuracy of the data. The decision to submit the manuscript has been solely of the authors. The authors have no source of support or proprietary interest in submission of this manuscript.

We hereby kindly request your review of the same and eagerly await your reply.

With kind regards,
Dr. Malvika Gupta