Reviewer's report

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

Version: 2 Date: 18 February 2010

Reviewer: amir pirouzian

Reviewer's report:

1. This is a much nicer written report and would like to thank authors for making the suggested changes.

2. There are a few more points I would like the authors to respond to before acceptance:

a. The intraocular pressures fell to early thirties but continued to be raised:
I would change the line to “to be elevated”.

b. After 6 months of surgery, at his regular monthly visit, an alteration in the tube position was noted. Tube of the AGV had migrated in the posterior segment, in the anterior vitreous cavity, just posterior to the lens, abutting the posterior capsule in the supero-temporal quadrant. A lens touch of the tube was evident (Figure2a & b):

The figure 2a/b do not show well the AGV tube to in the vitreous cavity posterior to the crystalline lens. The tube seems to be in the posterior chamber (not in posterior segment/vitreous cavity) but anterior the crystalline lens. Once again, if the tube has migrated into vitreous cavity, the authors should expect to find lenticular opacification. The other possibility is that the AGV migration has penetrated and passed through the zonules without lenticular touch due to the already existing and/or ongoing partial lens subluxation. Could the authors expand on this topic?

b. 44- 90%4-7.Multiple
Please add a space before “Multiple”.

c. The AGV tube had migrated to the posterior segment, just posterior to the lens, abutting the posterior capsule, in the supero-temporal quadrant where iris was hypoplastic with associated corectopia. Significant touch with the posterior capsule was seen but there was no evidence of any cataractous changes. Rest of the features remained unaltered with normal intraocular pressures. Possible hypothesis of such an anterior to posterior migration may be the gravitational pull of the AGV tube in the absence of iris support ( due to iris hypoplasia and corectopia ) in a child of active age group. Absence of cataract formation despite evident lens touch exemplifies the superior quality and biocompatibility of the polypropylene material used in AGV. Also development of cataract in such cases may not be immediate and focal lenticular changes may appear in due course.

Once again, I would like to ask authors if they have any additional photos to more
clearly and better show the actual position of AGV tube in anterior vitreous or posterior to crystalline lens.
e. I would ask the authors to add another paragraph citing the previously published report on anterior migration of AGV: “Transcorneal tube erosion of an Ahmed valve implant in a child. Al-Torbak A, Edward DP. Arch Ophthalmol. 2001 Oct;119.” I would also ask the authors to also add their comment and citation on role of radiological (MRI, etc) and ultrasound evaluation for position and surgical intervention following AGV implantation.

This is a well written concise manuscript and should be accepted with the addition of the above comments.

Thank you again for contributing.

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.