Author's response to reviews

Title: Management of significant reactivation of old disciform scars in wet Age-Related Macular Degeneration

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Author's response to reviews: see over
Dear Ms Cruz

Thank you for considering our manuscript to be published in the BMC Ophthalmology and for your comments from May, 2nd, 2014.

We appreciate your kind’s suggestions to improve the quality of our paper. The manuscript has been modified according to the comments of the reviewers. We think these changes may add for clarification. You can read first his comments and our answers bellow. We also added the correction of page and lines following the manuscript that I am resubmitting this time if changed.

**Answer to Reviewer 1**

1. Best corrected visual acuity is not described. Although the authors mentioned that V/A did not increase or decrease after treatment, it should be mentioned in each patient. It is interesting that in some cases, patients reserve some central vision although they have a large macular scar.

   **ANSWER:** Done, we added VA in each patient. All cases had VA under 20/200 and were considered not suitable for anti-VEGF drugs treatment according to our center’s protocol. Changes included, page 2 lines 21-28.

2. It is important to mention whether these patients were symptomatic or not. If they were asymptomatic there was no need for treatment.

   Ref PCV, periphery is equally important in such cases

   **ANSWER:** Done, all patients were symptomatic (page 2, line 20). Suggested reference is been added (page 4, line 4, reference number 11).

3. The second comment is based that the proportion of such patients that will have vitreous haemorrhage is minor. Peripheral vision is very important in such patients and should be treated only if they are symptomatic.

   **ANSWER:** I agree if they should be treated only if they are symptomatic (page 2, line 20), all these patients referred an increase in the size of their central scotoma.
However, I disagree with the statement of the reviewer on the rarity of HV in PCV cases. According to the literature 8.9% of patients with PCV will develop it after ranibizumab treatment and 6.59% after PDT. The risk of massive bleeding will be higher also in patients under antiagregant and anticoagulant treatment, something common in elderly (changes in text added in page 4, lines 1-4).

Answer to Reviewer 2

Reviewer’s report:

However, there are critical points that need to be considered and addressed prior to publication. Specifically, to help clinician answer whether ICG and subsequent focal laser may address this issue, especially with size and location of the neovascular bleeding, please address the following:

1. Approximately how soon from the time of each bleeding episode was laser used?

   ANSWER: Not all the patients presented large bleeding. If you have a look to the clinical features of each patient, you will find blood described only in:
   - Patient 1 presented a serous pigment epithelium detachment (PED) with some subretinal haemorrhage and lipidic exudation.
   - Patient 5 presented a haemorrhagic PED
   - Patient 6 presented a large subretinal haemorrhage with lipidic exudation
   - Patient 8 presented a large serous-haemorrhagic PED.
   - Patient 9 presented peripapillary subretinal haemorrhages
   - Patient 10 presented a large subretinal haemorrhage with a PED

   Thus, only patients 5, 6, 8 and 10 had significant bleeding.

   Anyway, we clarified that treatment was performed the same day of diagnosis (page 2, line 25).

2. If there was no view/access to the point of leakage, how did the authors ensure that there was proper laser photocoagulation pick-up or scarring

   ANSWER: We only treated visible hot spots on ICG. The only patient without an identifiable hot spot was not treated (page 2, lines 23-25).

3. What particular laser settings was used in each patient case?

   ANSWER: We added that in page 2, lines 26-29.

4. In the discussion, authors may require to address why it may be more or less beneficial to primarily treat with anti-VEGF intravitreal injections prior to laser photocoagulation to establish more efficient result of neovascular regression.
ANSWER: We already added some aspects on the discussion regarding advantages and disadvantages of treating these patients with anti-VEGF or laser photocoagulation (page 4, lines 11-16 and 30-35).

5. Authors may need to shed light on possible worsening of geographic atrophy and future neovascular episodes with the use of laser, which could be avoided if using anti-VEGF injections.

ANSWER: As we clarify in the text our patients had a fibrotic disciform scar without significant atrophy (pag 2 lines 20-21). Nevertheless we added some discussion on possible enlargement of laser scars (page 4 lines 15-16).

6. What were the average sizes of the geographic atrophy lesions? Could a greater size than average may predispose a patient to have break-through bleeding compared to patients with smaller GA?

ANSWER: All the patients included had a mainly fibrotic disciform scar after wet AMD, they could have some areas of geographic atrophy being the minor part of the lesion size. (Page 2, lines 20-21)

7. In the beginning of the paper the authors mention that the bleeding may be the polypoidal type of AMD. However the authors fail to shed light on this comment in the discussion section. Why was this important to bring up to the reader? Please clarify.

ANSWER: We added some comments on that at the discussion (page 4, lines 4-9)

8. Line 6 of page 4: need to remove comma prior the period (punctuation)

ANSWER: done.

Additional Editor’s Request:

(1) Please put Acknowledgment after Author's Contribution

ANSWER: done

(2) Requesting for Copy-Edit

We recommend that you ask a native English speaking colleague to help you copyedit the paper.

ANSWER: done