Author's response to reviews

Title: Methods of assessment of patients for Nd:YAG laser capsulotomy that correlate with final visual improvement

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Author's response to reviews:

Dear Sir/ Madam

Re: Methods of assessment of patients for Nd:YAG laser capsulotomy that correlate with final visual improvement

Thankyou for your time and effort and considered response to my submitted article. We submit our own response to these comments below and look forward to hearing from you again.

Tariq Aslam.
Niall Patton

Response to Reviewer 1; Michael Georgopoulos

General

The complex cases of patients with macular, corneal or vitreal pathologies were purposefully excluded from the study. All pathologies cannot be grouped together into one combined study and still give valid information about each individual type. By excluding these groups we were able to make our objective much more focussed, reliable and less subject to measurement error that would have additionally have arisen from trying to consider visual significance or severity of many different co-existing ocular pathologies. Information from this study can still be useful when dealing with many of those complex groups.

We agree that the most pertinent finding of fibrosis grading not correlating with vision importance should be highlighted and this has been corrected.

Points 1-3 corrected as requested
Point 4,7 and point 1 of reviewer 2, Ken Hayashi

Choice of grading system for PCO needed to have been validated and preferably established. One cannot make up a grading system and then start using it in experiments without evidence for its validity. We purposefully kept the scale to 5 grades of fibrosis and of pearls to improve reliability.[1] Using more may have made the scale worse by reducing reliability and validity. The scale used, devised by Lindstrom and Harris[2] was used after extensive investigation into known and tested alternatives. It is unambiguous and easy to apply. We believe that use of ambiguous terms such as "thin layer across visual axis" and "small pearls" would seriously reduce reliability and objectivity of the scale.

We used no other information to grade other than that given in the text but references are given to the original article if further information is required. One must remember that part of this study is intended to assess the very issue of a clinicians ability to assess PCO at the slit lamp. We present the findings for the use of this system, which we believe with current evidence to be as good as any described for use at the slit lamp without specialised equipment . We agree with Ken Hayashi that it is often difficult to classify fibrosis and pearl types of PCO and this is indeed one of our key points! We felt it important to assess PCO to no greater complexity that most clinicians did in order to maintain external validity of our findings.

Points 5-6 corrections made in text as suggested
Points 8,9 Reviewer here is concerned with PCO with coexisting pathologies and decision making with regard to this. This paper does not attempt to cover this complex area, which requires much further experimental work. It would therefore not be appropriate to address these issues here, but reference has been made to a recent review in Survey of Ophthalmology,[3] by the first author, where these issues are addressed.

Point 10 corrected as requested

Reviewer 2; Ken Hayashi

It is important to state that although current clinical practice concurs largely with the recommendations in our paper, nowhere in current literature has evidence for these findings been previously presented. We feel that findings that concur with and justify current practice should be as valuable as those that call for major change.

Point 1 addressed above

Point 2 The vision testing was done under standardised lighting conditions of luminance and illuminance. Charts were Bailey-Lovie LogMAR charts and Pelli Robson contrast sensitivity charts. These charts are widely used in research and clinical settings and valid for the purposes of this study.[4-6]

References