Author's response to reviews

Title: Good functional recovery following intervention for delayed suprachoroidal haemorrhage post bleb needling: a case report.

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Author's response to reviews: see over
Dear Editor,

Thank you for reviewing this paper and for the comments offered by your 2 reviewers. Please note the following changes.

In reply to Referee #1 Nathan Radcliffe’s comments:

1. We have changed the sentence structure in both the abstract and the main body of the case report to improve the language.
2. We have included a copy of the B-Scan performed at the time of the suprachoroidal haemorrhage and we have commented on the B-Scan findings in the text of the case report.
3. We have amended our occurrence rates of suprachoroidal haemorrhage following glaucoma surgery as advised by Dr. Radcliffe and have included a reference that he has kindly added in his review (Mardelli et al).
4. We have altered the conclusion to suggest that early surgical intervention may be beneficial in the management of this condition, as advised.
5. Other points on language have been addressed such as the use of semi-colons, and restructuring of certain sentences, the use of capitals for generic drug names have been altered and awkward sentences have been rewritten.
6. The language of the positive outcome has been toned down as advised.

In reply to Referee #2 Marlene Moster’s comments:

1. We have mentioned that the intraocular lens was posteriorly placed.
2. We have corrected all the figures so that the abstract and the main body of the case report are now consistent- the IOP has been changed to 16 mmHg in the abstract.
3. A short discussion on clopidogrel is included in the discussion.
4. Vitreous haemorrhage is associated with suprachoroidal haemorrhage and it is not necessary to have retinal break/tear present, Meier and Reynolds mention vitreous haemorrhage in their papers on this subject (both quoted in the paper). The original bleb needling procedure did not enter the eye, it was all carried out under the conjunctiva, therefore it could not induce a retinal tear.
5. There is much debate on the timing of surgical intervention in the management of suprachoroidal haemorrhage, and unfortunately there is little consensus.
The vitreo-retinal surgeon performed early surgical intervention in this patient as was no breach in the sclera/cornea. The initial bleb needling did not enter the eye. In situations where suprachoroidal haemorrhage follows intraocular surgery, it has been advised to postpone intervention until at least 10-14 days, but it is unclear when no preceding intraocular procedure has been performed. Meier and Reynolds advise early posterior sclerotomies in closed systems with a constant intraocular pressure, which is what we had. If the surgeon had waited 10-14 days, the second procedure may have been avoided, but it is impossible to make a comment on this for definite.

6. We have given more information on the initial bleb needling procedure, including using a 32-gauge needle, that the procedure was performed using an uneventful subtenon anaesthesia and that the healon was not placed in the anterior chamber. We do not cauterise the entry site. This technique was initially described by Professor P Khaw, London.

7. We have mentioned in the text that the anterior chamber was shallow prior to both vitreo-retinal procedures. Again the anterior chamber was shallow prior to the anterior chamber reformation.

8. We have altered the structure and wording of most of the sentences in an attempt to improve the quality of English.

I hope you find the amendments in keeping with the comments of the reviewers. With these changes addressed we wish to re-submit this paper to your journal.

Yours sincerely,

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