Author's response to reviews

Title: Unilateral thalamic infarction presenting as vertical gaze palsy

Authors:

Muhib Khan (mkhan4@hfhs.org)
Christos Sidiropoulos (chris.sid@gmail.com)
Panayiotis Mitsias (pmitsias@gmail.com)

Version: 5 Date: 2 June 2011

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

Thanks a lot for re-reviewing our article and providing us with valuable input to make this case report worthy of publication. We have addressed the issues raised by the reviewer’s as listed below:

Case Report

1. Stenosis of the right vertebral artery at the C4 transverse foramen secondary to extrinsic osteophyte compression was seen on magnetic resonance angiography and confirmed by catheter angiography.

The statement has been corrected as suggested and highlighted in yellow.

2. Transesophageal echocardiogram revealed an ejection fraction of 55% with no atrial or ventricular thrombus nor intracardiac shunt.

The statement has been corrected as suggested and highlighted in yellow.

Discussion

1. "The medial thalamus is supplied by perforating branches arising from the basilar communicating artery and posterior cerebral arteries. The midbrain is spared because the superior and inferior paramedian mesencephalic arteries arise separately from each other from the basilar communicating artery or P-1 segment of the posterior communicating artery (6)."

Please review this piece, there are contradiction. P-1 segment of the posterior communicating artery does not exist. The basilar communicating artery is a P1 segment of the posterior cerebral artery.

This statement has been amended and mentioning of P-1 segment has been omitted. The new statement is again highlighted in yellow.

2. The mechanism of vertical gaze paresis with unilateral lesions is uncertain but we can speculate on the possibility of decussation of the frontobulbar fibers in the medial thalamus, as suggested in a case series of thalamic infarctions presenting as vertical gaze palsies (9).

The statement has been corrected as suggested and highlighted in yellow.

3. The combination of vertical gaze paresis and skew deviation, previously believed to be pointing to a brainstem lesion, may now be attributed to a broader spectrum of anatomical areas.
The statement has been corrected as suggested and highlighted in yellow.

I hope that you will find the article worthy of publication

Thankyou again.

Muhib Khan MD
Senior Neurology Resident
Henry Ford Health Systems, Detroit, MI
USA