Author’s response to reviews

Title: Comparison of Outcomes of Unilateral Recession-Resection as primary surgery and reoperation for Intermittent Exotropia

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Dear Editor-in-chief

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Comparison of Outcomes of Unilateral Recession-Resection as primary surgery and reoperation for Intermittent Exotropia

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I am listed as a corresponding author on a manuscript submitted to BMC Ophthalmology entitled "Comparison of Outcomes of Unilateral Recession-Resection as primary surgery and reoperation for Intermittent Exotropia." Thank you for providing us the opportunity to revise the manuscript. Through the revision process, the reviewers have raised a number of points that enabled us to address the manuscript’s drawbacks and, we believe, improve it. We appreciate the reviewers and editor-in-chief for their valuable and constructive comments. Point-by-point responses to the comments are included below.

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Q3-4.

Comparing preoperative data between Group A and preoperative surgery #1 Group B in my will simply make this paper stronger. Did Group A patients did better than Group B first surgery. And if yes (since no second surgery was needed), why. It will help me as a reader decide when an R-R is needed as a second surgery.

A: The reviewer pointed out the same issue in questions 3 and 4. We investigated whether there was any difference in the surgical outcome of secondary R&R (reoperation) for recurrent exotropia as compared with that of primary R&R for intermittent exotropia. Accordingly, the subjects were assigned to one of two groups: group A, those who had been diagnosed as intermittent exotropia and underwent R&R as primary surgery, and group B, those who had been diagnosed with recurrent exotropia and underwent R&R as reoperation. The reviewer recommended that we compare the surgery in group A with primary surgery in group B. However, it was inappropriate to compare the outcome of surgery in group A with that of initial surgery in group B, because, whereas the patients in group A comprised both surgical success and failure cases, those in group B had all suffered relapse of intermittent exotropia (i.e., surgical failure) after the primary surgery. We were concerned that, if we modified the study design based on the reviewer’s comment, the study would have changed in its fundamental nature. Thus, we believe that such a modification would not meet the purpose of our study as originally conceived. We sincerely look forward to your kind consideration regarding this matter.

Q6.

Authors indicate the following "When we decided the surgical dosage of recess-resect, we refer to the preoperative angle of deviation at distance and near.". However, their methodology section says something different "All of the surgeries were performed by a single surgeon (D.G.C.) under general anesthesia according to the formula modified from the surgical table suggested by Parks (based on the angle of exodeviation at distance, Table 1) [18]. R&R was performed on the non-dominant eye in group A and on the unoperated eye in group B. In group B, all patients had undergone the unilateral R&R as primary surgery for intermittent exotropia"

A: Thank you for the comment. In determining the surgical recess-resect dosage, we referred to the preoperative angle of deviation at distance and near, especially for exotropia of convergence
insufficiency or the true-divergence excess type. In this study, all of the participating patients had been diagnosed with intermittent exotropia of the basic type according to Burian’s classification (page 5, lines 81-82). So, the preoperative angle of deviation at near was almost equal to that at distance in each group (Table 2). Thus, all of the surgeries were performed according to the formula modified from the surgical table suggested by Parks (based on the angle of exodeviation at distance, Table 1).