Author's response to reviews

Title: Comparison of the Efficacy of Intravitreal Triamcinolone Acetonide for Branch Retinal Vein Occlusion With SRD Versus CME: Influence on Macular Sensitivity and Morphology

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Author's response to reviews: see over
Dear Dr. Patel:

Thank you very much for your e-mail of April 25, 2012 and for your helpful and constructive comments about our manuscript (MS: 3891279356540496R3) entitled “Comparison of the Efficacy of Intravitreal Triamcinolone Acetonide for Branch Retinal Vein Occlusion With SRD Versus CME: Influence on Macular Sensitivity and Morphology.” According to the reviewers’ comments, we have revised our manuscript as described on the following pages.

We hope that the revised manuscript adequately addresses your concerns and those of the reviewers, and that our manuscript will now be considered acceptable for publication in your excellent journal.

Sincerely yours,

Hidetaka Noma

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Reviewer #1 Comments and responses

General Comments
Thank you for having a chance for reviewing this manuscript. This study aims to clarify the
relationships of morphological regression and functional improvement in patients with BRVO with
and without SRD after the administration of intravitreal triamcinolone. They found unique results
“the existence of SRD in patients with BRVO associated with CME influences on morphological
improvement, while not on functional progression.”
Although the purpose of this study is potentially interesting, there still seems to be some points to be
addressed in the study design.
Comment 1: First of all, I highly recommend the author to analyze the retinal area separately,
superior region of 12 cases and inferior regions of 9 cases, otherwise, it is hard to make a precise
discussion about morphological study of BRVO.
Answer:
Thank you for these valuable comments. As suggested, we exchanged the superior and inferior
regions because we wanted to divide the regions into those with bleeding and those without bleeding.
As a result, the superior region was always the occluded region and the inferior region was
non-occluded. We have now reanalyzed the data separately. This information has been added to the
Abstract, Methods, Results, and Discussion sections (page 2, lines 9-11, 13, 17-19, and 21 from the
top; page 6, lines 5-15 from the top; page 7, lines 3-10 from the top; page 7, line 7 from the bottom
to page 8, line 4 from the top; page 8, lines 10-28 from the top; page 9, lines 2 and 21 from the top;
page 10, lines 2, 5, 27-30 from the top).

Comment 2: In Addition, the authors stated “trend profiles of …..” but I am not sure the meaning of
“trend profile”. Please define “the trend profiles” precisely.
Answer:
Thank you for this helpful suggestion. We have defined “trend profile” in the Methods section (page
7, lines 15 and 16 from the top).

Specific Comments
Comment 3: Is there any difference of retinal thickness and retinal volume during this study? retinal
thickness and retinal volume Both parameters seems to be shown the same dynamic change,
therefore, only retinal thickness should be chosen.
Answer:
Thank you for this helpful suggestion. Since both parameters (retinal thickness and retinal volume)
showed the same dynamic changes, we have deleted all data on retinal volume.
Comment 4: The authors classified BRVO into CME and SRD, despite SRD includes CME. Thus for better understanding, BRVO should be classified as CME with and without SRD.

Answer:
Thank you for this helpful suggestion. The “SRD group” and “CME group” have been changed to the “CME with SRD; SRD (+) group” and “CME without SRD; SRD (-) group”, respectively (page 2, lines 6, 7, 12, 22-24 from the top; page 6, lines 20 and 21 from the top; page 7, lines 10, 11, 13, and 14 from the bottom; page 8, lines 6 and 8 from the top; page 9, lines 3-5, 19, 22-24 from the top; page 10, lines 2, 3, 6, 7, 16, 17, 26, 31, and 32 from the top).

Comment 5: In Methods, visual acuity of 20/33.3 is not familiar, must be 20/30.

Answer:
Thank you for this helpful suggestion. We have changed “20/33.3” to “20/30” (page 4, line 16 from the top).

Comment 6: Figure legends (Fig. 1 and 2) and figures (Fig. 1~10) were not corresponded. Please correct. Table 2 and 3 were the same as Figs, thus it should be deleted.

Answer:
Thank you for this helpful suggestion. The figure legends and figures now correspond properly (page 16, line 2 from the top to page 17, line 16 from the top) and Tables 2 and 3 have been deleted.

Reviewer #2 Comments and responses

Major Compulsory Revisions:

Comment 1: Revision of title to reflect better what the authors are trying to publish - ie a comparison of the efficacy of IVTA on SRD versus CME by assessing macular sensitivity and morphology

Answer:
Thank you for this helpful suggestion. The title has been changed to “Comparison of the Efficacy of Intravitreal Triamcinolone Acetonide for Branch Retinal Vein Occlusion With SRD Versus CME: Influence on Macular Sensitivity and Morphology” (page 1, lines 2 and 3 from the top).

Comment 2: The authors have defined SRD in the paper but fail to describe how they define CME

Answer:
Thank you for this helpful suggestion. We have now defined CME in the Methods section (page 6, lines 18 and 19 from the top).

Comment 3: The concept and importance of macular thickness/volume needs to be explained in
more detail as this was where the SRD and CME groups differed

**Answer:**
Thank you for these valuable comments. It has been reported that retinal thickness is greater in SRD patients than CME patients, and that injection of TA decreases retinal thickness in SRD patients. Therefore, we decided to investigate the differences between SRD and CME. These points have been added to the Introduction section (page 3, lines 13-15 from the bottom).

**Discretionary Revisions:**

**Comment 4:** The point of the study is in part lost on me as the authors themselves point out that SRD can also have CME present - so what is the point of separating out SRD and CME and looking to see response to IVTA in these 2 non exclusive groups

**Answer:**
Thank you for this helpful suggestion. As also described in the response to Reviewer #1 (comment 4), the terms “SRD group” and “CME group” have been changed to “CME with SRD; SRD (+) group” and “CME without SRD; SRD (-) group”, respectively, to improve the readers’ understanding (page 2, lines 6, 7, 12, 22-24 from the top; page 6, lines 20 and 21 from the top; page 7, lines 10, 11, 13, and 14 from the bottom; page 8, lines 6 and 8 from the top; page 9, lines 3-5, 19, 22-24 from the top; page 10, lines 2, 3, 6, 7, 16, 17, 26, 31, and 32 from the top).

**Comment 5:** A greater improved morphology in the SRD group is noted compared to the CME group - is this not due to the fact that SRD itself leads to a more abnormal morphology compared to CME on its own and so there is a greater room for improvement after IVTA?

**Answer:**
Thank you for these valuable comments. As suggested, there was greater improvement of morphology in the SRD group compared with the CME group. This may have been due to the fact that SRD itself causes a more abnormal morphology compared with CME, so that there may be greater room for improvement after IVTA. This point has been added to the Discussion section (page 10, lines 7-9 from the top).

**Comment 6:** I would like to see, if possible, more emphasis on the microperimetry results following IVTA over the 6 months follow up and how they improve and when any improvement may stabilise, etc

**Answer:**
Thank you for these valuable comments. As you suggested, the results of long-term follow up could be meaningful, but additional treatment such as triamcinolone acetonide or anti-VEGF agents for recurrence may bias the study. We would like to evaluate the long-term outcome in another study in
the future. We have added this as a limitation to the Discussion section (page 10, lines 20-22 from the top).