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Journal Name:	Journal of Advances in Medical and Pharmaceutical Sciences
Manuscript Number:	2014_JAMPS_12865
Title of the Manuscript:	Is Cystoid Macular Edema More Frequent In Vitrectomized Internal Limiting Membrane-peeled Eyes Undergoing Phacoemulsification?
Type of the Article	

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PART 1: Review Comments

	Reviewer's comment	Author's comment (if agreed with reviewer, correct the manuscript and highlight that part in the manuscript. It is mandatory that authors should write his/her feedback here)
Compulsory REVISION comments Line 85	The authors attempt to find out whether the timing of PE affects the incidence of CME in post-vitrectomized eyes for FTMH. However, there are several major flaws with this study: 1) The timing of phacoemulsification relative to the vitrectomy is not given. How long was the period between PE and PPV for the "before" group and how long was the period between PPV and PE for the "after" group. This is vital information as the authors are attempting to find out whether the timing of PE affects the incidence of CME. It would be very different if patient had PE 2 months vs 2 years after the vitrectomy. We know that it takes time (eg months) for FTMH to close post-vitrectomy. 2 The timing of OCT is not given. It is unclear from the methods section whether OCT was performed routinely pre-/post-vitrectomy and pre-/post-PE? If OCT was only performed when patient report drop in vision, then only symptomatic CME were detected. For tomographic CME to be picked up, a serial OCT should be performed eg 1-month, 3-month, 6-months. 3) FTMH is a major confounding factor for CME and increase CMT pre and post vitrectomy. For patients who underwent PE prior to the vitrectomy, what was the baseline and postop CMT? Was FTMH detected then? If so then perhaps the increased CMT and CME was	Line 85 Group 3 had a mean 12.3 (± 11.1) months interval between procedures. The interval between procedures is not known for group 4, as their first procedures were performed in other units and the exact details were unavailable. Line 146 The lack of perioperative data relating to the PE procedures of the group 4 patients limits our ability to assess their macular appearance pre and post PE. It is possible that CME could have developed post PE and contributed to the FTMH formation, but was no longer present when the patient presented to our care. Line 71 All patients had OCT scans at 1, 3, 6, 9 and 12 months post PPV or PE Group 4 were referred from other practices already pseudophakic with macular holes, so we don't have data prior to cataract surgery. But the interval between PE and onset of symptoms suggests that FTMH was not present at the time of cataract surgery



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	attributed to the pre-existing FTMH not pseudophakic CME per se. For the “after” group, we also need post-vitrectomy CMT data to determine if the PE did indeed cause an increase in CMT and CME. The authors postulate in their aim that it is PE that is causing the CME but in my opinion, both disease processes are contributory and it is difficult to attribute it solely to one or the other. 4) The timing of BCVA is not given. In the results section, BCVA at CME detection and at CME resolution were given. However, it is not mentioned when these were taken. What was the improvement of BCVA pre and post-vitrectomy for FTMH? 5) The statistics is very limited.	Line 85 Group 3 had a mean 12.3 (± 11.1) months interval between procedures. The interval between procedures is not known for group 4, as their first procedures were performed in other units and the exact details were unavailable. Line 146 The lack of perioperative data relating to the PE procedures of the group 4 patients limits our ability to assess their macular appearance pre and post PE. It is possible that CME could have developed post PE and contributed to the FTMH formation, but was no longer present when the patient presented to our care. Line 89 CME was noted in 6/43 patients (14%, Table 1), between 1 and 5 months post op (mean 3.3 months). What was the improvement of BCVA pre and post-vitrectomy for FTMH? Line 83 The mean ($\pm$ standard deviation; SD) LogMAR best-corrected mean visual acuity (BCVA) for all patients improved from 0.85 ± 0.37 to 0.49 ± 0.37 at 12 months postoperatively (Figure 1.) We have added p values to the table. Line 166 P value. Result of ANOVA comparison between groups 2, 3 and 4 with group 1. $P < 0.05$ was taken as statistically significant. Line 83 The mean ($\pm$ standard deviation; SD) LogMAR best-corrected mean visual acuity (BCVA) for all patients improved significantly
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	6) Also, the authors did not define what constitute to acute CME, late CME and recurrent CME.	from 0.85 ± 0.37 to 0.49 ± 0.37 at 12 months postoperatively (student's t-test: $p = 0.001$, Figure 1.) We took acute CME to be less than six months post-operatively, Late CME was greater than six months post-operatively and CME was deemed recurrent if it was detected 3 months after resolution of previous episode.
<u>Minor</u> REVISION comments	1) The type of OCT machine used (time-domain vs spectral domain) should be mentioned in the methods section 2) The authors has a control group (vitrectomy only, no PE) but this is not clearly mentioned in the methods section	Line 69 Spectral domain OCT (Cirrus HD-OCT, Carl Zeiss Meditec, Dublin, CA, USA) Line 72. The group of 8 patients who were phakic and had PPV/ILM peel for FTMH (group 1) acted as a control group as they did not undergo PE at any stage.
<u>Optional/General</u> comments	Overall a confusing paper with a lot of shortcomings.	We thank the Reviewer for their advice and feel that these suggestions have improved the quality of this paper