



SDI FINAL EVALUATION FORM 1.1

PART 1:

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	Short communication

PART 2:

FINAL EVALUATOR'S comments on revised paper (if any)	Authors' response to final evaluator's comments
There is a lot of improvement in the revised paper. However it still has a lot of unnecessary information which confuses its readers. Major points: 1) Line 19-25: The main aim of this paper is to see whether the timing of phacoemulsification relative to PPV affects post-operative CME. As such, CME rates for each subgroup should be given as the first line in the abstract's results section (Line 20) [and correspondingly given after patient's demographic information in the main manuscript results section (around Line 88)]. This then should be followed by a statistical analysis to see if it was statistically significant or not. Otherwise you cannot conclude that one form of treatment has higher incidence than the other! All other information are immaterial to the paper especially in the abstract section. We do not need to know how the CME was treated, whether they resolve or not, the BCVA for the entire group and the CMT for the entire group. If these data were to be presented, it would make more sense to give for each subgroup. In these kind of studies, usually the BCVA and CMT are presented for each subgroup and the similar statistical analysis can be made to see if there is any statistical significance. Figure 1 and 3 are unnecessary as it does not add information to the aim of the study. 2) Table 1: There is no statistical significance between these group therefore they cannot conclude that any of these subgroup sequence affected the outcome of CME. Furthermore, since this is a small group, I feel the authors need not subdivide the CME group further into tomographic, symptomatic and late recurrence. By taking that out, the p-value (from ANOVA) becomes clearer as I assume the authors were using total number of CME for each subgroup to compute. Minor points: 3) Line 88: For the case that did not close with the first procedure, how long later was the second procedure done? Ideally this case should be removed in the analysis because multiple surgeries will increase the chances of CME. If included, it would also complicate analysis because of the confusion in calculating the interval for post-op CME i.e. from the 1st procedure or the 2nd? 4) Line 90-92: This should be highlighted under limitation section in the discussion. Further limitation would include the fact that this is a retrospective study.	Thank you to the Final Evaluator for the kind advice. 1)Line 20 CME was noted in 6/43 patients (14%). CME occurred in 38% of group 4 compared to 0% of group 1, 11% of group 2 and 11% of group 3. This difference did not reach statistical significance when rates were compared to group 1 (Anova: group 2 p = 0.853; group 3: p = 0.876; group 4: p = 0.173). Line 87 OCT-evident CME occurred in 38% of group 4 compared to 0% of group 1, 11% of group 2 and 11% of group 3. This difference did not reach statistical significance when rates were compared to group 1 (Table 1; Anova: group 2 p = 0.853; group 3: p = 0.876; group 4: p = 0.173). Treatment info deleted from abstract. Figs 1 changed to depict subgroups Figure 3 Changed to depict subgroups 2) Line 182, we have clarified what the p value pertains to. P value. Result of ANOVA comparison between OCT-evident CME rates for, groups 2, 3 and 4 and group 1 (control). P < 0.05 was taken as statistically significant. We have elected to keep the tomographic, symptomatic and late recurrence values separated, because reporting only the OCT-evident data may be misleading to the reader. 3) The patient had repeat fluid gas exchange with C3F8, 4 months after the original procedure. They did not develop CME at any point. We have included them up to the 2nd procedure, because excluding them before this point induces a bias. 4) Line 156 Our study is limited by sample size and retrospective design. This limits our ability to extrapolate; however, this evidence justifies a large prospective randomized trial to elucidate the relative risk of the timing of phacoemulsification in such patients. The lack of perioperative data relating



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5) If OCT was performed at various interval: 1,3,6,9,12 months then the authors need to specify at which month was the CMT based on

to the PE procedures of the group 4 patients limits our ability to assess their macular appearance pre and post PE.

Line 111

With a mean decrease in CMT ($\pm$ SD) from 392.2 ($\pm$ 102.5) μ m preoperatively to 287.7 ($\pm$ 34.0) μ m at 12 months.

The mean CMTs at each time point are depicted in Fig3