



SDI Review Form 1.6

PART 1:

Journal Name:	<u>Ophthalmology Research: An international Journal</u>
Manuscript Number:	2013_OR_4789
Title of the Manuscript:	What is the normative size of the blind spot scotoma in adults?
Type of the Article	Others

General guideline for Peer Review process is available in this link:

[\(http://www.sciencedomain.org/page.php?id=sdi-general-editorial-policy#Peer-Review-Guideline\)](http://www.sciencedomain.org/page.php?id=sdi-general-editorial-policy#Peer-Review-Guideline)

- This form has total 7 parts. Kindly note that you should use all the parts of this review form.



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PART 2: Review Comments

	Reviewer's comment	Author's comment <i>(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)</i>
<u>Compulsory</u> REVISION comments	Q1. Title: the article should be identified as a systemic review Q2. Background, Line 47-48: "An enlarged blind spot scotoma is indicative of papilloedema alerting clinicians to investigate for raised intracranial pressure." The above sentence seems to suggest to the readers to look for enlargement of the blind spot as a clue for the presence of papilloedema. This is incorrect. In real clinical situations, papilloedema is diagnosed via fundus examination. Then clinicians will monitor the size of the blind spot. Besides papilloedema, there are many other causes of enlargement of the blind spot http://www.cybersight.org/bins/content_page.asp?cid=1-2897-3816-3819 Q3. The author should give the definition of a blind spot.	Now addressed see line: 2 Correct, this has been re-worded to avoid confusion. Addressed in the background paragraph two - line: 31 Now addressed in the background – line:29 Blind spot now defined in the opening paragraph – see line: 21



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	Q4. Line 67. As the size of the blind spot can be affected by the presence of refractive error and optic disc size, the author need to define “normal subjects”. Q5. Line 67-69: “The primary aim of this review is to establish the normative size of the blind spot scotoma in adults in order to aid identification of any scotoma enlargement.” The gold standard for perimetric measures of the visual field with kinetic stimuli is the manual technique involving Goldmann perimetry. Therefore the above question has already been answered by Armaly (1969). With the development of new technology, more convenient equipment (such as the Humphrey / Octopus) is used. However, Goldmann perimetry still remain the gold standard. Likewise, the gold standard for blood pressure measurement is the invasive arterial catheter system. But in practical terms, the sphygmomanometer is used. Q6. Line 87: The author wrote that “Although no study designs were to be excluded” Line 132-133: “The titles and abstracts were then matched against the protocol exclusion criteria” Please define the protocol inclusion and exclusion criteria	Addressed in Aims - line: 45 The Goldmann perimeter is considered the gold standard however it is no longer in production. It’s official successor is the Octopus 900. The Octopus 900 in theory is more accurate as you can ensure the kinetic stimulus moves at a constant speed and you can correct for the patients reaction time. It is on the Octopus 900 that we are lacking data & this review calls for further research. This question highlights the fact that normative data is different for each individual piece of equipment. I’ have now clarified this further in the conclusion – Line: 490 Protocol included as an appendix I. (line 641) See line: 107
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	Q7. Search Strategy. The author should list the KEYWORDS used in his search. I find that the author left out important articles such as the one below: Dolderer et al. Scotoma mapping by semiautomated kinetic perimetry: the effects of stimulus properties and the speed of subjects' responses. <i>Acta Ophthalmol. Scand.</i> 2006; 84: 338-344 Q8. Discussion, Line 414-420: "If papilloedema was suspected from fundoscopy urgent referral would occur regardless of a field result, however in cases where the appearance of the optic nerve head was ambiguous a definitive 'large' or 'outside normal limits' category could certainly aid clinicians taking management decisions. By being able to accurately identity an enlarged blind spot from visual perimetry further grading of papilloedema can be pursued, ensuring prompt referral for further investigation and appropriate interventions" I totally disagree with the above sentences. For the non-ophthalmologist, "whenever there is doubt please refer to the ophthalmologist". For the ophthalmologist, the presence of papilloedema can be easily determined with the presence of other	These are now listed in the methodology - see line: 97 This has now been included in the literature review. See lines; 112, 249, 263, 339, 355, 400, 428, (Plus table 1,2 and 3). This paragraph has been removed from the paper.
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	fundoscopic signs. The use of perimetry in the diagnosis of papilloedema is unnecessary and time consuming. Q9. Conclusion, Line 423-433. The author's conclusion is inappropriate. The gold standard for perimetric measures of the visual field with kinetic stimuli is the manual technique involving Goldmann perimetry. Although not wide used clinically nowadays, Goldmann perimetry remain the gold standard.	This has been addressed in the conclusion, the Goldmann is no longer in production and is successor is the Octopus 900 - see line: 490
<u>Minor</u> REVISION comments	-----	
<u>Optional/General</u> comments	-----	