



SDI Review Form 1.6

Journal Name:	Ophthalmology Research: An international Journal
Manuscript Number:	2013_OR_7034
Title of the Manuscript:	The Patient's Viewpoint of Cataract and Detached Retina Surgeries
Type of the Article	Is it a Case Report ?!

General guideline for Peer Review process:

This journal's peer review policy states that **NO** manuscript should be rejected only on the basis of '**lack of Novelty**', provided the manuscript is scientifically robust and technically sound.

To know the complete guideline for Peer Review process, reviewers are requested to visit this link:

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



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PART 1: 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>
Compulsory REVISION comments	I am impressed by explains and the diagrams drawing of symptoms and the expression of the complaints, which definitely correlates to the author's knowledge in the field. Respectable effort were done by author to write the manuscript but the type of the study, targeted audience and the text structure may need complete revision to augment the article value. The educational value is clear but I am confused about the targeted audience?	Of course the targeted audience is ophthalmologists. But another faction of our readership is the optometrist; intelligent layman, the medical student and friends and family of the patient .To make this clear, we have added the following section. 1.1 Who Should Read This Paper And Why Should They Read It? 1.1.1 Ophthalmologists Ophthalmologists can read this paper and diagnose the patient's medical problems. The symptoms and people interactions have been laid out in chronological order. These are the facts that were thought to be true at the time, but some of them might prove to be wrong in the end. The appendix provides useful and irrelevant data that he or she might want to consider. However, don't cheat and read the last part first. Hopefully, the ophthalmologist can learn a little about the patient's viewpoint of ocular surgeries. Finally the OX can decide if he/she would have done better than these dozen ophthalmologists. 1.1.2 Optometrists Optometrists can expand their horizons and find their place in ocular surgeries. In 1977, Larry Stark et al. [1] described many nontraditional optometry tasks that professionals were performing in his Neuro-optometry Clinic at Berkeley (UC) and San Francisco (UCSF). This paper suggests another nontraditional task: assisting patients with detaching retinas. Detached retinas seem to be in the purview of ophthalmologists. However, this paper explains ways that an optometrist was involved in (1) diagnosing a detaching retina, (2) tracking the specialties and equipment of local ophthalmologists, (3) acting as a primary visual care provider, (4) understanding and explaining to the patient what lies in store for him during and after the surgery, (5) diagnosing and perhaps solving postoperative complications {such as (a) postoperative diplopia, which (in this case) was ameliorated with prism spectacles, (b) the iris being trapped by the intraocular lens, which was solved by a lens replacement, (c) inflammation, in this case due to the suture securing the scleral buckle and (d) helping with pain diagnosis and remediation,} and (6) explaining the relationships between fundus photos, visual field



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	Here below are my comments:- Type of the study (design) Methodology is acceptable but quite long and	diagrams and ocular coherence tomography images. 1.1.3 Students of Optometry and Ophthalmology Students of Optometry and Ophthalmology can augment their diagnostic skills by practicing on this real-life case study. 1.1.4 Intelligent layman Intelligent laymen and patient advocates can learn about complications and interactions between cataract and detached retina surgeries. Such as the following. Pain is hard to diagnose measure, quantify and treat, making it frustrating for both the patient and the physician: in this case there were many causes of the pain, which caused confusion. There was no face-to-face communication between the dozen doctors that were involved in this case: furthermore, many times the written communications were not received, read or understood. In complicated procedures involving many physicians and many physical systems, perhaps there should be a patient's advocate, who knows the system and is interested only in the patients' best interests. A useful metric for choosing a doctor is the amount of time that he or she schedules for each appointment or operation. A better understanding and resolution for a medical problem may be treating the symptoms, the doctors, the patients and the procedures as a whole system instead of a group of specific symptoms to be treated individually. 1.1.5 Families and friends Families and friends of patients who have or will undergo ocular surgeries can understand what the patient is experiencing and what signs and symptoms should be reported to the ophthalmologist. When a new clue surfaces a very difficult decision is always, Should I call the doctor? Should I go to the emergency room? Reading this paper should help with that decision. I am willing to change the type of study to a case report or a design. I think we should ask our Editor for advice.
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	segmented. Lines 47-63 were an anterior vitrectomy done in the primary surgery? If yes was it Triamcelone (kanalog) assisted? Lines 214-220 were the cryo-probe use in office (clinic)? Lines 304-319 were there any refraction done? Was the patient having anisometropia? Was the IOL tilted or sub-laxated? Again not to explain the machines as the readers are ophthalmologists who know the OCT. Lines 333-335 the pupil measurement may not been checked as either is not expected to be affected or the office settings required an on-arrival pupil dilatation to allow better examination of the retina.	On page 6 of this “SDI-Review Form 1.6” I have placed the ophthalmologist’s description of this surgery. Would you like me to add any of these details to the manuscript? In the section September 12, 2008, I added a comment in the text saying that it was in the office. We are having a problem with referencing by line number. Lines 304-319 are not about the cataract surgery. I have added the following in the cataract replacement section. July 21, 2011, Lens Exchange Operation Ophthalmologist-9 noted significant posterior synechia superonasally, an eccentric pupil, and a chafe between the iris and the square edge of the intraocular lens. He performed refractive cataract surgery with peripheral corneal relaxing incisions. I have added the following. At most of my eye exams since May 2007, someone would measure the pupillary reflexes before dilation. The right eye was normal; the left eye was non-circular and non-responsive (tonic). I presumed that these test results were entered into my records and read by the doctor: but no ophthalmologist ever commented about this anisocoria.
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	From line 372 on the mentioning of UCLA is not go to add to the scientific material and can probably considered as advocating for a specific centre, same as Line 429 (UCLA). In discussion: comments about ILM peeling, is it on basis of valid references in relation to symptoms? I strongly suggest shortening the text keeping the intended ideas to highlight sequence of complications/management and the pain origin.	I have removed 5 of the 6 references to UCLA. I have added to the following section. October 20, 2009, Peeling the ILM Ophthalmologist-4 peeled the inner limiting membrane (ILM) over the macula. The inner limiting membrane is a diffusion barrier between the vitreous and the ganglion cells of the retina. It is about two microns thick. He removed an area about one mm in diameter. He did this manually, quite a feat! Then he injected Kenalog into the eyeball (fresh hospital Kenalog is preservative free). The purpose of peeling the ILM was to reduce the edema, not to improve visual acuity [3]; because visual acuity seldom improves after a macula-off detachment [Nadal et al., 2012]. Peeling of the ILM is used to repair macular holes. However, it has side effects. Tadayoni et al. [2012] wrote "ILM peeling may reduce retinal sensitivity, and significantly increase the incidence of microscotomas.... We found that mean retinal sensitivity was significantly lower ... in eyes that underwent peeling than in those that did not. Postoperative microscotomas were also significantly more frequent in eyes that had undergone peeling...." We have now shortened it all that we think we can.
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<u>Minor</u> REVISION comments	In the introduction, the optometrist's job described might be a point of conflict and that will add to their responsibilities, this might complicate the situation in underdeveloped centres of health service. To arrange Figures as per text (lines 75-84) text pointing to figure 1 then figure 3, it may be better to go in sequence of a,2,3. Lines 90,107 Prefluro = octafluoropropan) Lines 96-123 as the readers are ophthalmologists; this segment is better to omit.	I have reordered the sequence of mention of the figures. I have added this. inserted a bubble of perfluoropropane (C_3F_8) gas (also called octafluoropropane), a procedure known as pneumatic retinoplexy. This section might not be very useful to practicing ophthalmologists. But it may help the intelligent layman and the medical student.
<u>Optional/General</u> comments	Title can be more attractive if changed to nightmare of cataract surgery or case report of prolonged eye pain following cataract surgery written from patients Viewpoint	I thought deeply about this, but I decided that the other reviewers would object.



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	Centres mentioned may be interpreted as advocating for universities or medical schools could rise some points of grading skills or capabilities.	I removed five of the six mentions of UCLA.
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fact that care was taken not to inject very hard, as the wave spread across the posterior capsule indicating the dissection of the fluid between the nucleus and the posterior capsule there was an unusual reflex which suggested there might be a problem. Despite this the lens emulsification tip was then inserted into the eye. The lens was successfully emulsified into quadrants, each quadrant was removed maintaining the phaco tip in the central position in the anterior chamber without any problems. However, after removing the last portion of the nucleus it was apparent that the posterior capsule had torn as a result of the hydrodissection with balance saline, as there was a central defect in the posterior capsule. Because it had been broken as a result of the hydrodissection no vitreous had come forward and I was in fact able to aspirate most of the residual cortex without using any vitrectomy techniques prior to that. It was felt then in



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CARONDELET HEALTH NETWORK
ST. JOSEPH'S HOSPITAL
Tucson, AZ

OPERATION REPORT

order to make sure the vitreous would not create a problem an anterior vitrectomy was performed, small amount of residual cortex was removed from the capsular recesses and it was elected to insert MA60AC lens rather than the one-piece acrylic lens. Thus the wound was enlarged slightly, this was then folded and placed into the eye. The haptics were fixed in the sulcus and the lens optic was then prolapsed through the rhexis anteriorly so the optic was within the capsular bag. This was completed without difficulty. The anterior chamber was examined. There was no evidence of any vitreous in the anterior chamber. Weck-cel was used to test the edge of the wound, there was no evidence of any vitreous there. Vitrector was used to remove the Viscoat which was used to protect the cornea during insertion of the lens from the anterior chamber. Miochol was instilled to constrict the pupil. There was no evidence of any traction on the pupil during constriction, nor again testing with Weck-cel was there any evidence of vitreous left in the anterior chamber. A single cross-stitch suture was placed in the wound because it had been enlarged slightly and I did not want it to leak. Iodine was placed on the eye along with Maxitrol