



SDI Review Form 1.6

Journal Name:	Ophthalmology Research: An international Journal
Manuscript Number:	2013_OR_8098
Title of the Manuscript:	Role of Magnetic Resonance Imaging in Herpes Zoster Ophthalmicus Ophthalmoplegia
Type of the Article	Case Study

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 (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	This interesting and informative report could be presented more clearly. 1) Comment: Isn't symmetric visual acuity unexpected when one eye has keratitis? Comment? 2) Comment: Instead of "Hutchinson sign," why not say "interstitial keratitis" (if that is what the author means)? Some readers will not know the eponym, and others will associate it with syphilis. 3) Comment: What is a "dendritic epithelial ulcer"?	We would like to thank the reviewer for all his comments. 1) Reply: If the location of keratitis does not affect the visual axis or the extent of keratitis is not serious, the visual acuity can still be preserved. 2) Reply: I am sorry for causing the confusion. Hutchinson sign in HZO is the skin lesion on the tip of the nose which strongly correlates to ocular involvement. This is because the nasociliary branch of the trigeminal nerve innervates both the cornea and the tip of the nose. In order to clarify it, we have added explanatory note of Hutchinson sign to my manuscript accordingly. 3) Reply: Dendritic ulcer is the characteristic clinical sign of acute epithelial keratitis in HZO. It is characterized by dendritic lesions which are smaller and finer than herpes simplex dendrites, and have tapered ends without terminal bulbs. Instead of dendritic epithelial ulcer, we have changed it into dendritic ulcer in my manuscript accordingly.



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	4) Comment: Figure 2 is difficult to interpret on my reproduction, but it and the Hess screen seem to show decreased elevation whether the right eye is abducted or adducted, reflecting weakness of both superior rectus and inferior oblique. The imaging, however, showing enhancement of superior and inferior rectus, would predict decreased elevation and depression maximal during abduction. Moreover, pupillary involvement implicates inferior division involvement. Do these dissociations, reflecting the combination of myopathy and neuropathy, merit specific comment? 5) Comment: The Discussion refers to "ophthalmoplegia" as "a transient self-limited condition," but all we know about this patient is that after 8 weeks she was "improved." What improved, and to what degree? Was her recovery eventually complete?	4) Reply: The interpretation of the correlation between our clinical findings and neuroimaging results does merit specific comment. Based on the clinical findings of our patient (limitation of right eye elevation, dilated pupil), both superior and inferior divisions are involved, which correlates with the enhancement of the oculomotor nerve along the cisternal, intracavernous and intraorbital portions shown in MRI. However, significant limited depression was not detected in this patient, which cannot be completely explained by the 3rd cranial nerve palsy. Thus, other aetiology may exist. Interestingly, in our patient MRI not only showed thickening and enhancement of right oculomotor nerve suggestive of neuritis, but also enhancement of ipsilateral extraocular muscles considering acute orbital myositis. Nevertheless, how orbital myositis contributed to the questionable eye movement in our patient remains unknown. We have revised our interpretation of clinical findings and neuroimaging results in the discussion part accordingly. 5) Reply: After 8 weeks, complete resolution of ophthalmoplegia with full extraocular movement was noticed in this patient. We have modified our manuscript accordingly.
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	6) Comment: The Abstract says that either neuropathy or myopathy as seen with this patient can be diagnosed with CT. Nothing in this report supports that conclusion, and I doubt that this patient's thickened enhancing oculomotor nerve would have been detected by CT. Does the 1977 reference (ref 8) provide such an example? 7) Comment: The last sentence of the Introduction says that cases with MRI-confirmed combined neuritis and myositis "have rarely been reported. Can the author provide a reference? 8) Comment: The English needs work. For example, in the Introduction, "While...or MRI," is a non-sentence.	6) Reply : We are sorry for the confusion the statement has caused. Orbital myositis can be diagnosed either by CT or MRI. However, cranial nerve enhancement can only be detected by MRI. Ref 8 provides the example of MRI or CT confirmed orbital myositis. 7) Reply: The reference has been provided and highlighted accordingly. 8) Reply: We have modified it accordingly.
<u>Minor</u> REVISION comments		
<u>Optional/General</u> comments		