

Dear Editor,

Thank you very much for your decision letter and advice on our manuscript (Manuscript NO:61130) entitled “**Inadvertent globe penetration during retrobulbar anesthesia: A case report and literature review**”. We also thank the reviewers for the constructive comments and suggestions. We have revised the manuscript accordingly, and all amendments are indicated by red font in the revised manuscript. In addition, our point-by-point responses to the comments are listed below this letter.

This revised manuscript has been edited and proofread by *Medjaden* Bioscience Limited.

We hope that our revised manuscript is now acceptable for publication in your journal and look forward to hearing from you soon.

With best wishes,

Yours sincerely,

Tao Sun

Corresponding author

E-mail: Suntao_13003@163.com

First of all, we would like to express our sincere gratitude to the reviewers for their constructive and positive comments.

Replies to Reviewer 1

1. Why did you preferred Retrobulbar block as Peribulbar regional block is always safe and why RBB was again repeated although by an expert surgeon?

Response: Thank you for your insightful suggestion. The perforation rate is lower with peribulbar anesthesia than with retrobulbar anesthesia, so the technique is considered safer, but peribulbar anesthesia is less effective than retrobulbar anesthesia. When patients undergo pars plana vitrectomy, retrobulbar injection is recommended. The junior ophthalmologist noticed some resistance during retrobulbar anesthesia, at the time of needle insertion. The patient felt severe pain. Subsequently, subconjunctival hemorrhage and an altered red reflex were observed. We considered the possibility of inadvertent globe penetration during retrobulbar injection. An incorrect angle of needle insertion may have resulted in inadvertent globe penetration. Therefore, an expert surgeon re-administered retrobulbar anesthesia.

2. What were the dimension of needle attached to syringe?

Response: 38 mm.

3. What was the axial length of the globe(short/long)?

Response: 22.97 mm.

4. During the RBB procedure did the surgeon sucked the syringe and looked for ocular movements after penetration?

Response: Thanks for your thoughtful suggestion. During the first RBB procedure, inadvertent globe penetration was found before the surgeon created negative pressure in the syringe. When we re-administered retrobulbar anesthesia, the surgeon created negative pressure in the syringe. After penetration, no obvious impairment of ocular movement was observed.

5. Do you have facility to give ultrasonic guided regional blocks? 6. Please write in longer paragraphs wherever possible. Thanks

Response: Currently, we do not have access to a facility that is appropriate for the administration of ultrasonic-guided regional blocks. We added some sentences (highlighted in red) to address your comment in the revised manuscript.

Recently, Foad et al.^[1] tried to explore the accuracy and safety of real-time ultrasound-guided retrobulbar regional anesthesia, as compared with blind technique, for cataract surgery. Foad et al.^[1] used the Siemens® ACUSON X600™ Ultrasound System. Ultrasound-guided retrobulbar regional anesthesia allows for real-time visualization as the needle advances and as local anesthetic spreads^[1]. Foad et al.^[1] reported that ultrasound-guided retrobulbar injection may decrease risk for sight-threatening or life-threatening complications.

The steps are as follows: the probe is placed vertically in the outer quadrant of the upper eyelid of the closed eye; the probe is held between the index finger and thumb; the index finger is placed on the lower eyelid to push the globe upwards; then, the needle is introduced. Once the needle is placed at the appropriate point, the probe may be removed^[1].

Replies to Science editor:

Issues raised:

(1) I found the authors did not provide the original figures. Please provide the original figure documents. Please prepare and arrange the figures using PowerPoint to ensure that all graphs or arrows or text portions can be reprocessed by the editor.

(2) I found the authors did not add the PMID and DOI in the reference list. Please provide the PubMed numbers and DOI citation numbers to the reference list and list all authors of the references. Please revise throughout.

(3) I found the “Case Presentation” did not meet our requirements. Please re-write the “Case Presentation” section, and add “FINAL DIAGNOSIS”, “TREATMENT”, and “OUTCOME AND FOLLOW-UP” section to the main text, according to the Guidelines and Requirements for Manuscript Revision.

(4) the author should number the references in Arabic numerals according to the citation order in the text. The reference numbers will be superscripted in square brackets at the end of the sentence with the citation content or after the cited author's name, with no spaces.

Response: Thanks for your constructive comments and suggestions. Corrections have been made in the revised manuscript.

Replies to Company editor-in-chief:

I have reviewed the Peer-Review Report, full text of the manuscript, and the relevant ethics documents, all of which have met the basic publishing requirements of the World Journal of Clinical Cases, and the manuscript is conditionally accepted. I have sent the manuscript to the author(s) for its revision according to the Peer-Review Report, Editorial Office's comments and the Criteria for Manuscript Revision by Authors.

Response: Thanks. We have revised the manuscript accordingly, and all amendments are indicated with red font in the revised manuscript.

Reference

1. Foad AZ, Mansour MA, Ahmed MB, Elgamal HR, Ibrahim HEE, Elawamy A. Real-time ultrasound-guided retrobulbar block vs blind technique for cataract surgery (pilot study). *Local Reg Anesth* 2018 ;6; 11:123-128 [PMID: 30584353 DOI: 10.2147/LRA.S178771]