

Article information: <https://dx.doi.org/10.21037/amj-23-4>

**Reviewer A**

**Comment 1-** The fundoscopic image I reviewed was not labeled. For teaching purposes, it would be helpful to demonstrate the findings clearly with labels or arrows.

**Reply 1:-**

These are the labeled images

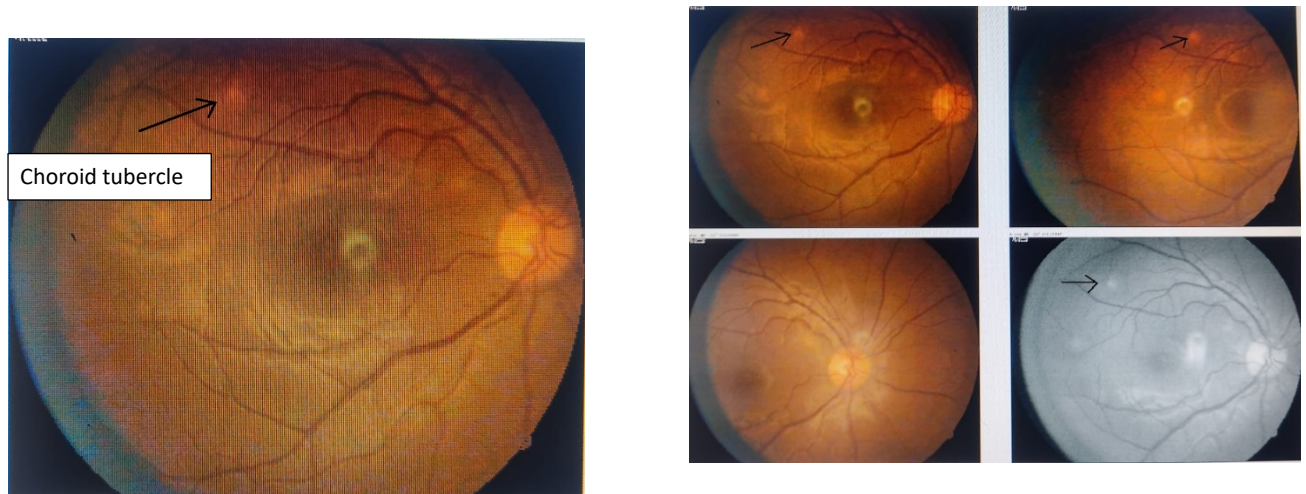


Fig. 1 fundoscopic images of patient showing choroid tubercle with marked arrow

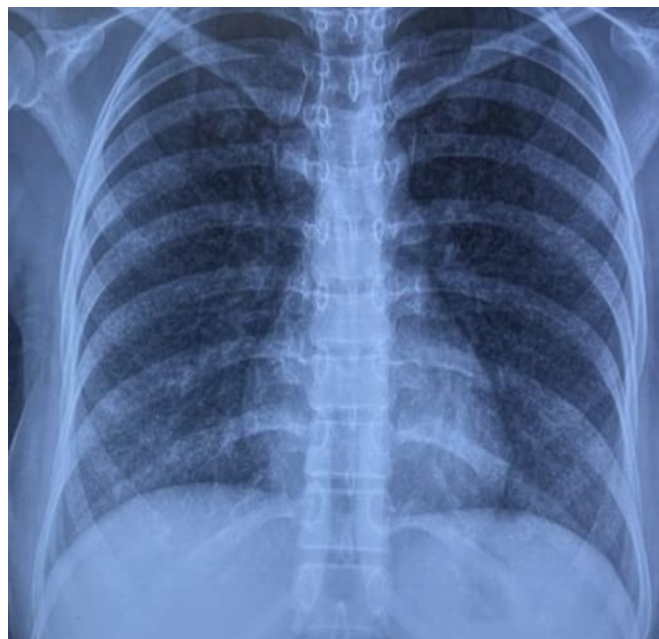


Fig. 2 – Chest X-ray of patient showing Patient's X-ray showing millet seed sized tubercular foci shadows

Changes in text -We added labelled image of fundus examination of patient showing choroid

tubercle in form of Fig. 1 and image of Chest X-ray showing miliary Kochs in form of fig. 2 on page 2 of main manuscript

**Comment 2-** Patient's presentation is interesting as she had minimal systemic symptoms despite having widespread, likely subacute miliary TB. It may be worth mentioning that she had subacute or chronic TB as opposed to acute/fulminant TB. Her age may also have been helpful, and a mention of any other serious medical issues that may have predisposed her to the miliary form of infection.

**Reply 2-** Patient had subacute illness, her age was 27 years, but had no history of any comorbidity, her viral markers and HIV status was negative

Changes in text – we added age of patient 27 years and comorbidity status in line 9 and 14 of page 1 of main manuscript

**Comment 3-** The manuscript I reviewed did not have references attached, so I was unable to review these.

**Reply 3-**

#### REFERENCES

1. Bates M, Marais BJ, Zumla A. Tuberculosis comorbidity with communicable and noncommunicable diseases. *Cold Spring Harbor perspectives in medicine*. 2015 Nov 1;5(11):a017889.
2. Shah A, Kunal S. Miliary tuberculosis. *Clinical Focus Series. Tuberculosis: Selected Problems*. New Delhi, Jaypee Brothers Medical Publishers. 2019 Sep 30:128-54.

Changes in text – we added reference on page 3 of main manuscript

## **Reviewer B**

This paper is a case report of ocular tuberculosis complicated by miliary tuberculosis. Ocular tuberculosis is a relatively rare disease that is associated with about 1% of cases diagnosed with tuberculosis. In addition, if diagnosis is delayed, it can lead to blindness, so it is considered to be a valuable case report. However, this paper is problematic in many ways.

**Comment 1-** First, there is little evidence for diagnosis as tuberculosis. Miliary tuberculosis has a diffuse small granular shadow indicating a random distribution in both lungs, and it is necessary to prove *Mycobacterium tuberculosis* from clinical samples or histologically prove epithelioid granuloma. In addition, in order to prove ocular tuberculosis, the detection of bacteria from the local area is the most important. Before the introduction of the PCR method, it was necessary to identify *Mycobacterium tuberculosis* from ocular tissue and secretions by smear or culture, but it was difficult to make a definitive diagnosis of ocular tuberculosis because a sufficient amount of sample could not be collected and acidophilic bacteria culture generally did not result in positive results in aqueous humor or vitreous puncture. However, in recent years, the introduction of the PCR method has made it possible to identify pathogenic microorganisms from a small number of samples. In addition, for the diagnosis of tuberculous meningitis, it is necessary to present the details of the cerebrospinal fluid findings and prove the tuberculosis bacteria.

**Reply 1-** We wished to have a definitive diagnosis of tuberculosis based on the criteria as you have mentioned. However, the patient declined for any invasive intervention, as neither she had any fulminant tuberculosis symptoms nor ocular symptoms. Therefore, we diagnosed this patient clinicoradiologically as a case of miliary tuberculosis with choroid tubercle as shown in fig 2 having millet seed sized tubercular foci shadows and started on treatment.

Changes in text – we added this text in discussion part of main manuscript on page 1 of main manuscript.

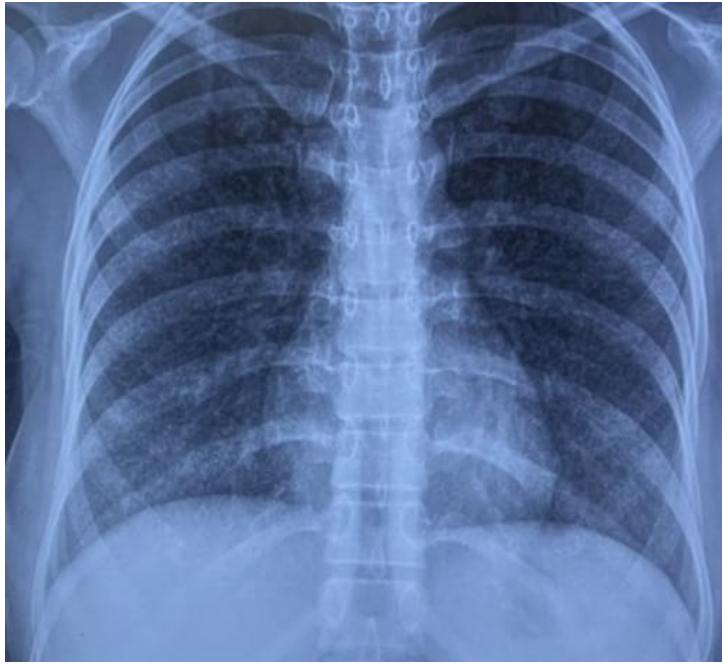


Fig. 2 – Chest X-ray of patient showing Patient's X-ray showing millet seed sized tubercular foci shadows

**Comment 2-** Details such as fundus examination should also be indicated, and details of eye lesions such as vitreous, retina, etc. should be indicated.

**Reply 2-** On fundus examination bilateral eye media was clear with cup disc ratio was 0.3:1, AVR – 2:3 foveal reflux was present with disc margin defined, with multiple choroid tubercle on posterior pole.

Changes in text - We added detailed fundus examination of patient in line 21 of page 1 of main manuscript

**Comment 3-** Please present age, underlying disease, history of tuberculosis, and chest imaging findings.

**Reply 3-**

Patient's age is 27 years, without any underlying disease, without previous history of tuberculosis and her chest X-ray had multiple millet seed sized tubercular foci as shown in fig 2, suggesting miliary TB

Changes in text - We added Patient do not have any history of previous tuberculosis or any other comorbidity in line 14 of page 1 of main manuscript.

**Comment 4-** Please indicate the treatment of tuberculosis medication.

**Reply 4-**

Following medication started:-

Tab. Isoniazid 250 mg once daily

Tab. Rifampicin 450mg once daily

Tab Ethambutol 800 mg once daily

Tab Pyrazinamide 1200 mg once daily

Patient is currently in 2<sup>nd</sup> month of intensive phase of anti-tubercular therapy, after 2<sup>nd</sup> month of intensive phase patient will be shifted on continuation phase

Changes in text – we added treatment in line 2 of page 2 of main manuscript

**Comment 5-** It is necessary to indicate the course of eye lesions, etc. after the start of tuberculosis treatment.

**Reply 5-** Patient has improved symptomatically, on sequential fundus examination, choroid tubercles has improved as shown in Fig 3.

Changes in text – we added sequential fundoscopic images of patient showing regression in choroid tubercle after 2 months of treatment on page 3 of main manuscript.

