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Sir,
Frosted branch angiitis

We read with interest the article by Walker *et al*¹ on frosted branch angiitis review, and would like to draw attention to our paper entitled 'Unilateral frosted branch angiitis with vitreous haemorrhage',² a case of an Indian patient, which they missed in referencing. There are very few patients from outside Japan, and this case of ours makes it two patients from India.

There are certain points, which we would want to make, that have not been stressed in the frosted branch angiitis review.¹ It is of note that frosted branch angiitis is usually bilateral and very rarely unilateral, there being very few cases of unilateral frosted branch angiitis.^{2–4} The uniqueness of our case, besides being the second reported patient of primary frosted branch angiitis from India, was its unilateral nature and development of a dense total vitreous haemorrhage; these patients may present with a vitreous haemorrhage, as happened in our case.²

Also, primary retinal phlebitis/Eales' disease being very common in India, we have seen about 10 cases of Eales' disease that at places had frosted branch angiitis-like appearance (Figure 1), again raising the issue whether frosted branch angiitis is a separate disease entity or a clinical sign being increasingly recognized in various inflammatory conditions,⁵ frosted branch angiitis-like clinical picture already having been described in

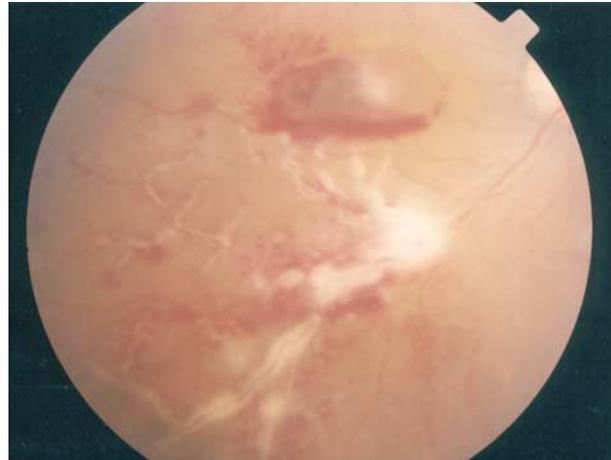


Figure 1 A 25-year-old Indian male presenting in the acute inflammatory stage of Eales' disease. He had blurred vision in right eye of 1 week; the retinal phlebitis gives the appearance of frosted branch angiitis at places. He improved with oral steroids in 1 month. The other eye was lost following neovascularization, vitreous haemorrhage, and tractional retinal detachment from old Eales' disease.

conditions like cytomegalovirus retinitis, etc.^{2,5} The course of these Eales' disease cases was similar to that found in frosted branch angiitis patients. No investigations were positive and all responded well to oral corticosteroids. Many patients of Eales' disease commonly develop neovascularization with intraocular haemorrhaging. This phenomenon, again, is being increasingly recognized in frosted branch angiitis as well.^{6,7}

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Sir,
Reply to S Agrawal *et al*

We are grateful to the Doctors Agrawal for their interest and comments on our paper. They comment that we have not stressed the fact that frosted branch angiitis (FBA) is 'very rarely' unilateral. In fact our extensive literature review found that 25% of 'primary' FBA cases are unilateral and that was stated in our paper.¹

The association of localized 'secondary' FBA with other retinal vasculitides was commented upon and illustrated in our paper, although the possible association with 'Indian' Eales' disease (a form of retinal vasculitis extremely common in the subcontinent, and typically presenting with substantial perivascular exudate) is interesting. We have also witnessed substantial exudate in these patients, but rather like sarcoid phlebitis, it tends to have a distinct opacity to it in comparison with the translucent frosted appearance which we have illustrated in our paper. We therefore wonder whether this is truly the same phenomenon. Clearly, there are instances of retinal ischaemia and neovascularization in patients with a frosted branch appearance. Whether all such patients should be labelled as 'Eales' disease' is open to debate, as there appears to be little agreement on the diagnostic boundaries for that disease.

There is, clearly, clinical variability to FBA, and the possibility of ischaemic complications should be borne in mind, as for any patient with retinal vasculitis.

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Sir,
Cataract surgery after intravitreal injection of triamcinalone

I read with interest the article entitled 'Cataract surgery after intra-vitreous injection of triamcinalone acetate' by Jonas *et al.*¹ They have concluded that cataract surgery following intra-vitreous injection of triamcinalone is safe. This conclusion is based on a very small sample size of 22 cases. The posterior capsular rupture rate was calculated to be 4.5% based on one patient. I would expect the confidence interval to be large. The incidences of posterior capsular rupture in various reports have ranged between 1 and 4.8%. It is, therefore, difficult to draw any conclusions.

Secondary cataract was seen in one patient. A mean follow-up of 3.76 + 4.99 months is too short a period to reveal the true posterior capsular opacification rate.

Furthermore, with a reported incidence of postoperative endophthalmitis ranging between 0.04 and 0.2%, it is impossible to make any comments on the endophthalmitis rate based on a sample of 22 cases.

I feel that the conclusions have been overstated.

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