

Indeed, data were taken simultaneously for both eyes of an individual and both eyes were used for analysis. However, only right eye per patient was entered into the study because there was no significant difference in any of the parameters between right and left eyes. Seasonal allergic conjunctivitis was diagnosed according to the guidelines of diagnosis and treatment of conjunctivitis (Ben Ezra D. Guidelines on the diagnosis and treatment of conjunctivitis. *Ocul Immunol Inflamm* 1994). Reference 3 was according to the guideline in this journal. Table 1 contained both the profile of the patients and the results of ocular biometry; therefore, the profile of the patients should be put in the method section as he suggested.

We thank Professor Dantas for the important comments regarding the corneal structural changes in the allergic conjunctivitis. We also think the presumption that the configuration of the corneal surface leads to allergic conjunctivitis is not important for the relationship between refraction and allergic conjunctivitis. Education level and socioeconomic factor rather than the configuration of the corneal surface may be important factors adding to the risk of allergic sensitization in patients with myopia. The comments of Professor Dantas were so helpful to understand the relationship between the changes in corneal structure and corneal inflammation. Thanks again.

#### Reference

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Sir,  
Reply to MR Romano *et al*

Romano *et al*<sup>1</sup> present some interesting data regarding the use of intravitreal bevacizumab (IVB) before diabetic vitrectomy, and its effect on the rate of postoperative vitreous cavity haemorrhage (POVCH). We were interested in the authors' assertion that the preoperative IVB resulted in a reduction in the rate of late POVCH but not early or persistent POVCH after initial surgery. This is contrary to the findings of Yang *et al*,<sup>2</sup> who found a reduction in the rate of early, but not late haemorrhage, and Yeoh *et al*,<sup>3</sup> who reported a 54% POVCH rate in non-oil-filled eyes in their series using preoperative IVB. Although the study by Romano *et al*<sup>1</sup> was an uncontrolled pilot study, these differences perhaps deserve some explanation.

Romano *et al*<sup>1</sup> attribute the reduction in rate of re-bleeding to the use of the preoperative dose of IVB. We

note that IVB was also given at the completion of surgery after fluid–air exchange. Do the authors consider this extra dose of IVB to have had an effect on late re-bleeding?

Although there are conflicting reports, air and other tamponade agents have also been noted to have an effect on POVCH.<sup>4</sup> The authors report fluid air exchange: was air exchange used in all cases for its haemostatic effect, or just in selected cases to tamponade retinal breaks? Was gas used? In addition, was the dose of IVB adjusted in any way to allow for the reduced volume of distribution after fluid air exchange? If not, the absence of any toxic effect is important and is of clinical relevance.

Finally, Yeoh *et al*<sup>3</sup> considered that one explanation for their high re-bleed rate was the inadequate intraoperative laser because of apparent inactive retinopathy at the time of vitrectomy secondary to the use of preoperative IVB. Romano *et al*<sup>1</sup> reported using endolaser photocoagulation and further detail regarding this would be useful. For example, Yeh *et al*<sup>5</sup> reported a significant reduction in the late re-bleed rate by the addition of confluent anterior cryotherapy to the peripheral retina, and many surgeons now routinely use endolaser to the anterior retina to reduce late re-bleed rates.

#### Conflict of interest

The authors declare no conflict of interest.

#### References

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