Sir,
Reply to Corneal hysteresis in eyes undergoing phototherapeutic keratectomy

We appreciate the insightful comments of Drs Qiu and Zhang on our published article.[1] We had shown earlier that eyes with higher intraocular pressure (IOP) are more predisposed to having lower corneal hysteresis (CH), indicating that IOP levels may affect the measurement of CH.[2] After phototherapeutic keratectomy (PTK), we topically administered the steroid, fluorometholone (0.1%), four times daily for 1 week, the dose being gradually reduced thereafter. However, the corneal compensated IOP measured with an Ocular Response Analyzer (Reichert Ophthalmic Instruments, Depew, New York, USA) was 15.8 ± 3.8 mm Hg preoperatively and 16.3 ± 3.9 mm Hg 3 months postoperatively. No significant IOP rise as a result of the response to the steroid occurred in any eye during the follow-up period. Accordingly, we consider that IOP did not significantly affect the measurement of CH in eyes undergoing PTK in this study.

Conflict of interest
The author declares no conflict of interest.

References
1 Kamiya K, Shimizu K, Ohmoto F. The changes in corneal biomechanical parameters after phototherapeutic keratectomy in eyes with granular corneal dystrophy. *Eye* 2008; 19 December 2008 [e-pub ahead of print].
2 Kamiya K, Hagishima M, Fujimura F, Shimizu K. Factors affecting corneal hysteresis in normal eyes. *Graefes Arch Clin Exp Ophthalmol* 2008; **246**: 1491–1494.

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Sir,
Features of common variable immunodeficiency

I read with interest the article by Harsum *et al*.[1] The authors state that the diagnosis of common variable immunodeficiency (CVID) is made on the clinical history of recurrent infection, usually of the respiratory tract, in the context of reduced total IgG. However,
Some points need to be clarified. Other causes of hypogammaglobulinaemia, for example, nephrotic syndrome and haematological malignancies, must be ruled out before the diagnosis of CVID has been made. So complete blood count with differential, urine protein analysis must be performed.[2] History of medications is also crucial. Corticosteroids, gold salts, penicillamine, antimalarial drugs, sulphasalazine, fenclofenac, phenytoin, and carbamazepine can contribute to hypogammaglobulinaemia.[2]

References
1 Harsum S, Lear S, Wilson P. CVID causing a granulomatous uveitis and optic disc neovascularisation mimicking sarcoid. *Eye* 2009; **23**(1): 241–242.
2 Park MA, Li JT, Hagan JB, Maddox DE, Abraham RS. Common variable immunodeficiency: a new look at an old disease. *Lancet* 2008; **372**(9637): 489–502.

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Sir,
Response to Kittisupamongkol

We thank Dr Kittisupamongkol[1] for his interest in our case and for drawing attention to a key aspect of diagnosing primary immunodeficiency—serum antibody levels reflect rate of production and loss and this can be influenced by a long list of pathologies which must be excluded before diagnosing CVID. We can confirm that our case meets full diagnostic criteria as outlined by the European Society of Immunodeficiency,[2] and that further investigation was undertaken to identify new pathologies such as mycobacterial infection.

Where immune deficiency is suspected, an initial panel of investigations should be undertaken to exclude haematological malignancy autoimmune disease, renal disease, and HIV. A thorough medical, surgical, and drug history should identify iatrogenic immune deficiency. Further investigations to exclude defined cellular immunodeficiency or genetic disorders can be undertaken by the immunology laboratory.[3]

Conflict of interest
The authors declare no conflict of interest.

References
1 Kittisupamongkol W. Features of common variable immunodeficiency. *Eye* 2010; **24**: 744.
2 www.ESID.org. Date accessed 14/06/09.
3 de Vries E. Clinical Working Party of the European Society for Immunodeficiencies (ESID). Patient-centred screening