

The authors take the right eye for analysis, ignoring the left eye without any test of correlation between them to validate the use of just one eye as the subject.

In the definition of 'seasonal allergic conjunctivitis' (SAC), the authors enumerate the symptoms and cite conjunctival follicle as associated with SAC, which is not true. Papillae are the main biomicroscopic, histological, and anatomical finding associated with SAC.

- Reference 3 is incorrect. The correct version is *Ocul Immunol Inflamm* 1994; 2(Suppl 1): S17–S34.
- In the Results section, Table 1 displays demographic data (number of patients, gender, and age). For methodological reasons, these data pertain to the Materials and methods section, because they are not result of any analysis, only the source/material.
- The conclusion that the configuration of the corneal surface leads to allergic conjunctivitis is inaccurately interpreted by the authors. What the literature shows is that with the allergic process (commonly in vernal keratoconjunctivitis), a complex process involving biochemical (enzymes and enzymatic inhibitors) and cellular (apoptosis) disturbances, which leads to stromal thinning, increase in the corneal curvature and consequently myopic astigmatism.^{2–4} Moreover, in susceptible individuals, long-term allergic disease with a chronic traumatic factor on the corneal epithelium could be related to keratoconus, because, as Kim *et al*⁵ pointed out that persistent and chronic corneal trauma on the corneal epithelium (in this particular situation, itching or chronic trauma provoked by giant papillae), induces a 'silent' and chronic inflammatory process, leading to progressive loss of stromal mass and consequently to less biomechanical resistance, and thus to anterior corneal steepening, decreasing the optical competence of the anterior corneal surface.

Scientific data support the affirmation that chronic allergic conjunctivitis may be a risk factor for myopic

refractive error. In contrast, no consistent data have shown the opposite.

References

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Eye (2010) **24**, 386–387; doi:10.1038/eye.2009.91;
published online 1 May 2009

Sir,
Response to Dantas *et al*

We appreciate the comments expressed by Professor Paulo (EC) Dantas¹ PEC regarding our paper about 'Relationship between Refraction and Allergic Conjunctivitis' published in the October 2007 issue (Mimura *et al*, 2007).

Table 1 Comparison of ocular biometry and refraction between patients with and without seasonal allergic conjunctivitis

	Non-contact lens wearers		t-test	Contact lens wearers		t-test
	Patients with SAC	Patients without SAC		Patients with SAC	Patients without SAC	
Number of patients	224	659		73	59	
Male/Female	68/156	284/375		22/51	16/43	
Age (years)	47.5 ± 20.2	51.4 ± 22.4	0.0077	31.3 ± 10.9	30.1 ± 12.0	NS
Spherical equivalent (D)	−3.01 ± 3.83	−1.36 ± 3.08	<0.0001	−5.47 ± 2.79	−5.31 ± 2.79	NS
Sphere (D)	−2.64 ± 3.63	−1.05 ± 2.88	<0.0001	−5.02 ± 2.62	−4.91 ± 2.75	NS
Cylinder (D)	0.91 ± 0.90	0.89 ± 0.81	NS	0.93 ± 0.78	0.85 ± 0.65	NS
Corneal radius (mm)	7.68 ± 0.31	7.69 ± 0.30	NS	7.78 ± 0.37	7.85 ± 0.43	NS
Maximum corneal refractive power (D)	44.55 ± 1.80	44.45 ± 1.76	NS	44.20 ± 2.12	43.75 ± 2.37	NS
Minimum corneal refractive power (D)	43.44 ± 1.89	43.41 ± 1.83	NS	42.83 ± 1.96	42.55 ± 2.14	NS

D = diopters; NS = not significant; SAC = seasonal allergic conjunctivitis.
Values are expressed as mean ± SD.

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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Eye (2010) **24**, 387–388; doi:10.1038/eye.2009.92; published online 1 May 2009

Sir,
Reply to MR Romano *et al*

Romano *et al*¹ 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*,² who found a reduction in the rate of early, but not late haemorrhage, and Yeoh *et al*,³ who reported a 54% POVCH rate in non-oil-filled eyes in their series using preoperative IVB. Although the study by Romano *et al*¹ was an uncontrolled pilot study, these differences perhaps deserve some explanation.

Romano *et al*¹ 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.⁴ 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*³ 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*¹ reported using endolaser photocoagulation and further detail regarding this would be useful. For example, Yeh *et al*⁵ 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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Eye (2010) **24**, 388; doi:10.1038/eye.2009.119; published online 29 May 2009