

Sir,
Reply to Dr Taub

We would like to thank Dr Taub¹ for his interest in our correspondence.² In response, we would like to address two issues that he has raised.

Firstly, when an 'accident' occurs as a result of a recommended therapy or intervention, this is termed a complication. All therapies have potential complications and need to be considered on the basis of their risk and benefit profile. If patients are encouraged to repeatedly hit homemade pendulums at eye level, ocular trauma is a complication that deserves consideration. Any equipment used in such exercises should be designed to be as safe as possible to minimize the risk of ocular injury. In light of this case, the particular behavioural optometrist involved is going to modify the construction of the equipment used for this exercise.

Secondly, Dr Taub implies that we intended this case report to somehow represent adequate reason to 'strike out at all of behavioural optometry'. It is not. Arguments regarding efficacy are discussed in thorough literature reviews performed by other authors.^{3,4}

References

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Sir,
Comment on 'Reduction of thickness of ganglion cell complex after internal limiting membrane peeling during vitrectomy for idiopathic macular hole'

We read with interest the article on 'Reduction of thickness of ganglion cell complex after internal limiting membrane peeling during vitrectomy for idiopathic macular hole' by Baba *et al.*¹

In the discussion regarding the possible mechanisms of ganglion cell complex (GCC) thickness reduction, it is noteworthy to include that indocyanine green (ICG) can cause the alteration in the surgical planes during internal limiting membrane (ILM) peeling in macular hole (MH) surgery. In a study by Gandorfer *et al.*,² all membrane

specimens from ILM peel revealed not only the ILM, but also some small amounts of retinal elements, such as the plasma membrane of Müller cells and other undetermined structures. This indicates a cleavage plane not exactly at the outer undulating aspect of the ILM but within the outermost retinal layers, which would account for the thinning of the GCC layer.

The conclusion by the authors in this study is controversial. ILM peel may improve the success of anatomical closure of a MH. Macular hole surgery, with or without the use of adjuncts, had high success rates prior to the recently accepted practice of ILM peeling. It is our understanding that many centres do not perform an ILM peel routinely for certain stages of MH and despite this, achieve high rates of anatomical closure. Smiddy *et al.*³ reported a high anatomic MH closure rate of 93% with a complete, partial or no ILM peel. Brooks Jr⁴ reported 82% primary anatomical closure of MH without ILM peel. ILM peel is not essential for MH <300 µm and <6 months in duration, and its value in other stages of macular hole is still not proven, though widely accepted. We suggest that, ILM peel may aid in MH closure but is not essential as the authors concluded in their study.

Conflict of interest

The authors declare no conflict of interest.

References

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- 2 Gandorfer A, Haritoglou C, Gass CA, Ulbig MW, Kampik A. Indocyanine green-assisted peeling of the internal limiting membrane may cause retinal damage. *Am J Ophthalmol* 2001; **132**: 431–433.
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Sir,
Reply to Dr Soong and Mr Saha

We appreciate the comments of Dr Soong and Mr Saha¹ concerning our article.² We reported a thinning of the ganglion cell complex (GCC) and a significant correlation between the thickness of GCC and retinal sensitivity