obtain a contemporary snapshot of the clinical management and surgical approaches.

The survey explored five clinical scenarios: Scenario 1. How do you manage a retinoschisis with a localised, asymptomatic macula-on retinal detachment? Scenario 2. What is your surgical approach for PSRDR in the presence of a significant cataract? Scenario 3. What is your approach for a PSRDR with an anterior outer leaf break (OLB)? Scenario 4. What is your approach for a PSRDR with an OLB posterior to the equator? Scenario 5. What is your approach for a PSRDR complicated by grade B or grade C proliferative vitreoretinopathy (PVR)? Eight-four completed responses were received, including consultant vitreoretinal surgeons (77.4%), and VR fellows/specialists (14.3%). The reported annual vitrectomy surgery caseload was 101–300 in 64.3% ($n=54$) and 301–500 in 25% ($n=21$). The majority (57.1%, $n=48$) of surgeons undertake 6–20 scleral buckle procedures annually. The numbers of PSRDR cases managed annually were as follows: 0 cases (8%); 1 case (30%); 2 cases (30%); 3 cases (20%); 4 cases (7%); and 5 cases (5%).

In scenario 1, 15% surgeons monitor patients with serial imaging. Laser barrage treatment was undertaken by 17% of surgeons, with 10% opting for vitrectomy. The remainder of respondents would observe the patients in the outpatients clinic using slitlamp biomicroscopy without any imaging. For scenario 2, 80% would undertake combined phacoemulsification and vitrectomy surgery and 8% combined vitrectomy with lensectomy. Regarding refractive choice, 58% surgeons place a posterior chamber lens implant and 4% leave the patient aphakic. Unfortunately, 38% of surgeons did not complete their refractive choice, and the authors can only tentatively presume that a posterior chamber lens implant was placed following phacoemulsification surgery.

In scenario 3, 31% undertake cryotherapy and scleral buckle surgery, with external drainage in 5%. The remainder of surgeons elect to perform vitrectomy with retinopexy; 47% vitrectomy with gas, of which schisis deroofing/retinotomy is done in 20%; vitrectomy with oil is undertaken in 14%, combined with schisis deroofing/retinotomy in 7%; and vitrectomy with scleral buckle surgery is undertaken by 6% of surgeons. In scenario 4, all surgeons perform vitrectomy with retinopexy. In 70% surgeons, the preferred approach is vitrectomy with gas, of which schisis deroofing/retinotomy is performed by 28%. Vitrectomy with oil is the preferred choice for 26%, with combined vitrectomy with scleral buckle surgery in 3%. In scenario 5, primary vitrectomy surgery is undertaken. The majority use oil tamponade (64%) with schisis retinectomy performed by 23%; and gas tamponade by 16% with 4% employing retinectomy. The remainder of surgeons perform combined vitrectomy with scleral buckle surgery, with gas in 6%, oil in 14%, and retinectomy plus oil in 7%. Across all groups for PSRDR, the overall success rate from primary surgery was difficult to interpret. This survey is not a valid method to estimate the results/success rates of the various treatment options, as each surgeon would be dealing with very few cases and recall bias can significantly alter the true outcome estimates.

This survey highlighted the current variation in the management of PSRDR for specific clinical scenarios. The self-reported success rates for surgeons within the BEAVRS group for primary surgical intervention was not reliable, as this survey is based on individual surgeon recall of a rare surgical case(s). Grigoropoulous and co-workers[3] report that PSRDR associated with anterior OLBs have better outcomes than those with posterior OLBs, and PSRDR with PVR have poorer outcomes. Optimal surgical management continues to be the subject of ongoing debate at a national level within the vitreoretinal surgical community.

The contemporary variation in clinical management and surgical approaches for this condition is highlighted by our survey. There is a lack of contemporary epidemiological data for PSRDR, and further studies are required. In the era of revalidation and benchmarking of surgical outcomes in the United Kingdom, the authors will be conducting a prospective multicentre study of PSRDR within the United Kingdom in association with the British Ophthalmic Surveillance Unit.

Conflict of interest

The authors declare no conflict of interest.

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Sir,

Intravitreal injections, antibiotics and endophthalmitis

The article by Lyall *et al*[1] entitled 'Post-intravitreal anti-VEGF endophthalmitis in the United Kingdom: incidence, features, risk factors, and outcomes' is timely, given current efforts to minimize the risk of endophthalmitis following intravitreal injections. We take great interest in this topic, and support the authors' efforts to identify risk factors for endophthalmitis.

However, we are concerned with biases inherent to their study design and the limitations of using data from questionnaires. Our three major issues include questionnaire validation, lack of povidone-iodine data, and inadequate control group selection.

The use of questionnaires to obtain information about clinical case histories, treatments, outcomes, and complications is subject to inaccuracies. The authors do not state whether the questionnaires used were validated. Without an attempt to validate the questionnaire, one cannot be certain about the accuracy or validity of the data.[2]

Although the authors acknowledge that data regarding povidone-iodine were not collected, the failure to administer povidone-iodine may have been the underlying risk factor for many of the 47 endophthalmitis cases reported. Povidone-iodine is well known to reduce the rate of endophthalmitis after intraocular surgery.[3]

The authors conclude that failure to administer both immediate pre and post-injection antibiotics is a risk factor for endophthalmitis. The data provided in Table 2 reported that only 8.7% ($n=4$) of the eyes in the study group with endophthalmitis did not receive immediate post-injection topical antibiotics *vs* 0% of the control group. The control group used 10 randomly selected sites and was not an appropriate control group. The control cases should have been obtained from the same sites where the study cases were obtained, in order to decrease any unknown biases.

Lyall *et al*'s[1] conclusions are over-reaching regarding the 'protective' effects of administering immediate pre and post-injection antibiotics. The lack of questionnaire validation and povidone-iodine data as well as the presence of an inadequate control group should have been addressed. Furthermore, the study should not have been used to serve as an endorsement for the use of topical antibiotics.

Conflict of interest

The authors declare no conflict of interest.

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Sir,

Reply to Bhavsar *et al*

We would like to thank Bhavsar *et al*[1] for their critical reading of our manuscript.[2] They correctly highlight the need for a proper method of developing and validating questionnaires. In the reference they cite, the authors advocate that a questionnaire should be designed as part of a systematic, prospective case ascertainment system.[3] We did exactly this as part of the British Ophthalmological Surveillance Unit (BOSU) framework. Both authors of the citation[3] were also on the BOSU committee that reviewed our study before it commenced and personally critically appraised our questionnaire and overall methodology. The committee was also composed of a statistician and independent specialists in the field. We also piloted our questionnaire on one local case of endophthalmitis and several control cases to ensure its robustness. This method of data collection and reporting has been used in multiple BOSU studies in the literature (PubMed search term: 'British Ophthalmological Surveillance Unit'), with all questions in our questionnaire framed in a similar manner.

We appreciate the work done by Bhavsar and others to advocate not using topical antibiotics during intravitreal injections.[4] Our study, which presents data on 47 cases of post-intravitreal anti-VEGF endophthalmitis (PIAE), is still one of the largest data sets in the literature with the primary aim of studying PIAE.[2] Other studies, with the primary aim of studying the efficacy of anti-VEGF therapy, draw conclusions on the use of topical antibiotics based on statistical analysis of fewer overall injections and incident PIAE cases.[4]

We disagree with the comments regarding our case–control selection. As we performed a prospective, national surveillance study, we selected 10 control centres from across the country to avoid any regional or single centre bias. Individual control cases were selected randomly, again to avoid any bias. This was done in order to obtain control data that was as representative as possible of the national population receiving anti-VEGF therapy at that time. This method has been reported in the literature.[5]

As acknowledged, we discussed the reasoning for not including data on the use of povidone-iodine in our manuscript.[2] It was in fact the BOSU committee who recommended that we did not include this in our questionnaire as part of the strict, independent, peer review process. We agree that povidone-iodine reduces the bacterial flora on the ocular surface, as does modification of many of the other risk factors that we identified in our study. The use of povidone-iodine is regularly used as part of standard practice throughout the United Kingdom. Therefore, to attempt to discredit the valuable risk factor data we report by suggesting that