Sir,
Intravitreal aflibercept for choroidal neovascularisation in angioid streaks

We appreciate the interest demonstrated by Tetikoglu *et al*[1] in our publication regarding the use of intravitreal aflibercept as primary treatment for choroidal neovascularisation (CNV) in angioid streaks (AS).[2]

Currently, anti-vascular endothelial growth factor (VEGF) drugs are the treatment of choice for AS-associated CNV and in this setting, aflibercept is regarded with interest as it has a higher affinity for VEGF-A, as well as the ability to bind VEGF-B and placental growth factor.[2] Therefore, it is perfectly reasonable to observe patients refractory to bevacizumab[1] and ranibizumab[3] to be switched to aflibercept therapy, in alignment with what has been observed in other macular diseases, such as neovascular age-related macular degeneration.[4]

In addition, we agree with Tetikoglu *et al*[1] that the recurrence time of the AS-associated CNV is not just depended on the drug used. Recurrence seems to be a multifactorial event difficult to predict, with some patients needing repeated injections, while others can be activity-free for several years or even develop new CNV lesions.[3,5] Nevertheless, these case reports[1–3] suggest that aflibercept is a valid effective option to be considered.

Conflict of interest

Dr SVP has received consultant fees from Bayer and Novartis and has received travel grants from Bayer, Novartis, Alcon, Allergan and Alimera Sciences. Dr LC has received travel grants from Bayer. Dr GDS has received travel grants from Bayer and Heidelberg Engineering. The remaining author declares no conflict of interest.

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Sir,
Comment on: 'Long-term outcomes of neovascular glaucoma treated with and without intravitreal bevacizumab'

In their retrospective study Olmos *et al*[1] compared the long-term outcomes of neovascular glaucoma (NVG) treated with and without intravitreal bevacizumab (IVB; Avastin; Genentech Inc., San Francisco, CA, USA) injections in a large-case comparison study. The authors concluded that vision and intraocular pressure (IOP) in the eyes with NVG treated with bevacizumab showed no long-term differences when compared with eyes that were not treated with bevacizumab. We would like to address some issues regarding the bevacizumab treatment in patients with central/hemicentral retinal vein occlusions (central/hemi-CRVOs)-related NVG.

The assertion made by Olson *et al*[1] that bevacizumab only delays the need for glaucoma drainage implant surgery, serving as an effective temporizing rather than a definitive treatment, is valid only for the fully developed form of NVG (angle-closure glaucoma stage[2]). However, treatment with IVB injections is a very useful intervention in the early stages of NVG, that is, the prerubeotic, preglaucomatous (rubeosis iridis), and early open-angle glaucoma stages of NVG,[2] for prevention or even cure of NVG[3] by ablation of the ischemic drive for new vessel formation. We demonstrated, for the first time,[3] that the prevention of NVG may be enhanced in patients with central/hemi-CRVOs by IVB injections administered as early as possible after the onset of occlusion. Specifically, we prospectively evaluated the cumulative prevalence of NVG in patients with acute (≤1 month after the occlusion was diagnosed) central/hemi-CRVOs treated with IVB injections.[3,4] The treatment consisted of four consecutive IVB injections given off-label in a dose of 2.5 mg per injection ~45 days apart followed by *pro re nata* administration over a period of 3 years. No adverse effects or ocular toxicity, including clinically evident sterile or infectious endophthalmitis, IOP increase, retinal ruptures, retinal detachment, and systemic tromboembolic events were encountered during the study. The cumulative prevalence of NVG was 4.08%, a value significantly different from that existing in patients with untreated acute CRVOs (28.5%).[5]