research tasks to each trainee, and provide required support. This will help senior trainees to develop the mentoring skills before they become a consultant and help the junior trainees to acquire the required research skills. A multifaceted research framework integrated with experienced academic faculty was shown to enhance trainees' research participation and scholarly output.[5] In terms of authorship guideline, the members of NETRiON agreed that some authors, who were more significantly involved in the study, should be named in the publication and all other trainees who have contributed to the data set would be listed as collaborators.

Overall, there was a strong positive attitude amongst the ophthalmology trainees towards the establishment of TRN. Clear authorship guidelines, good supervision, provision of research training and evidence of research output generated from the network can help promote a sustainable trainee-led research network. We hope that future collaborations with other TRNs will occur.

Conflict of interest
The authors declare no conflict of interest.

North East Trainee Research in Ophthalmology Network (NETRiON)
Members of NETRiON who had contributed to the data set (listed in alphabetical order):
T Bommireddy, YM Chen, A Cunningham, K El-Assal, M Grinton, C Henein, E Hill, D Loganathan, D Lunt, H Madi, MC Markham, I Masri, C Matthew, M McKenna, A Mehta, JY Ng, Y Olaoye, K Oswal, R Rana-Rahman, J Sandhu, A Shwe-Tin, J Suleman, D SJ Ting, E Ting, M Vrahimi, GY Wong.

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Eye (2018) **32,** 476–477; doi:10.1038/eye.2017.202; published online 15 September 2017

Sir,
Comment on: 'One-year real-world outcomes in patients receiving fixed-dosing aflibercept for neovascular age-related macular degeneration'

We read with interest the clinical study of Almuhtaseb *et al*[1] on real-world outcomes in patients receiving fixed dosing aflibercept for neovascular age-related macular degeneration.

We would like to share our experience with a modified IVAN protocol that seems more cost effective than PRN, Treat-and-extend, and *Fixed dosing* in comparison to Almuhtaseb's Table 2 while maintaining MARINA-like outcomes (Figure 1). The IVAN protocol was defined as '*re-treat with IVI x 3*' in case of disease activity.[2] Our modification was to drop the follow-up visits between a course of three consecutive intravitreal injections (IVI) similar to current fixed dosing regimes.

Our mean number of doses per year with modified IVAN are 3.6 (Figure 2).

Our mean number of outpatient visits with OCT and VA are 10.4 (Figure 3).

Aflibercept versus Ranibizumab usage is currently ~50% in our service.

This results in a cost of this pathway of ~£4124 per patient per year. This is significantly cheaper than PRN (£8920), Treat-and-extend (£9968.70), and Fixed dosing (£6919).

A modified IVAN protocol offers the best of both worlds as the element of fixed dosing provides predictability of service demand and patient satisfaction due to the ability to pre-book three consecutive injections. The PRN element reduces the risk of over treatment as well as overall injection frequency. VA outcomes are similar to monthly Ranibizumab (Figure 1).

Conflict of interest

ARN has received consultancy fees and travel grants from Novartis and Bayer.

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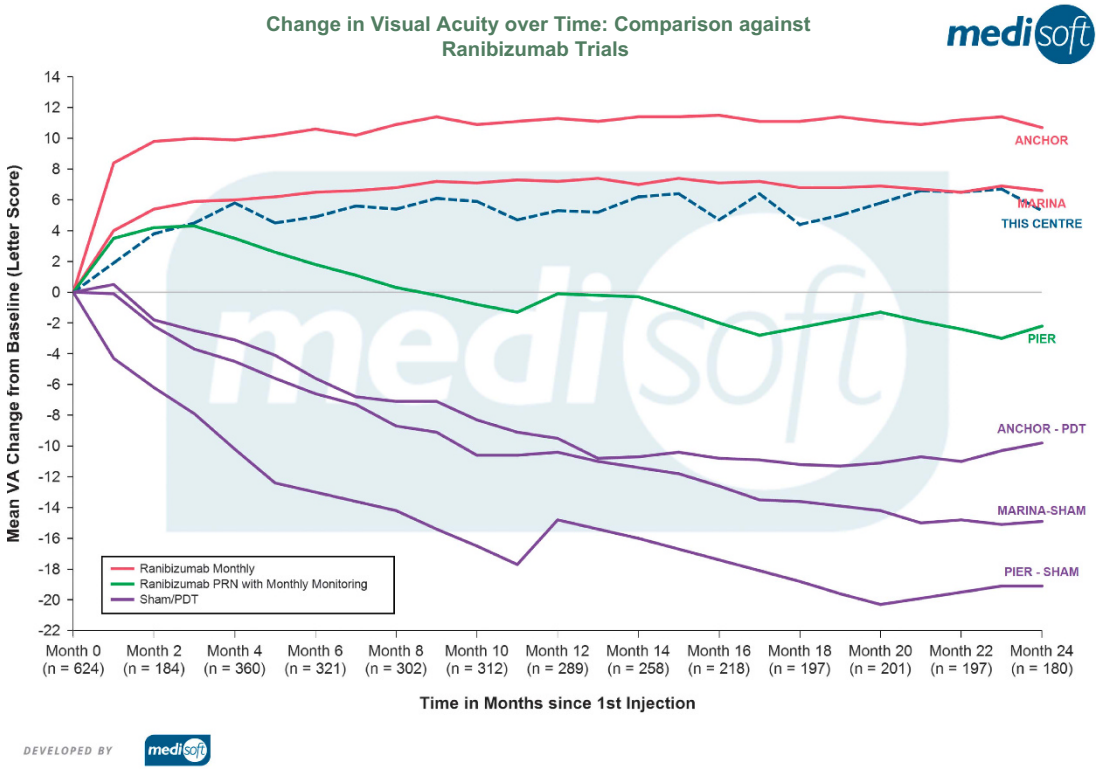

Figure 1 VA outcomes with a modified IVAN protocol. 'This Centre' = North Devon District Hospital.

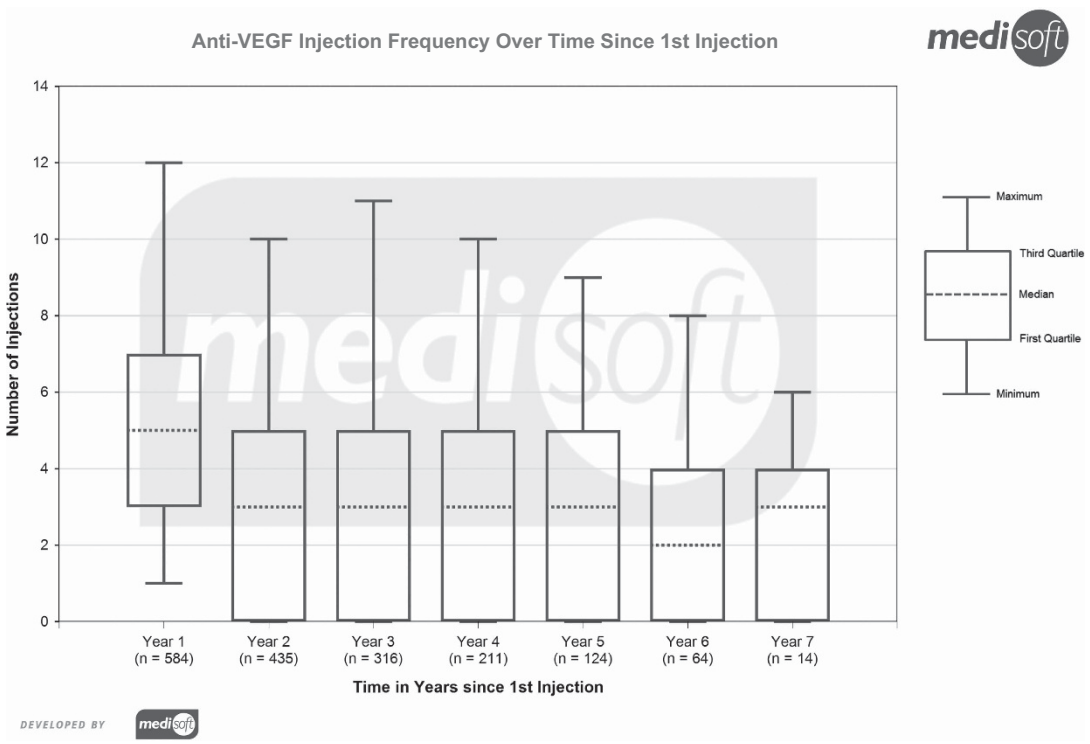

Figure 2 Anti-VEGF injection frequency over 7 years (2009–2016).

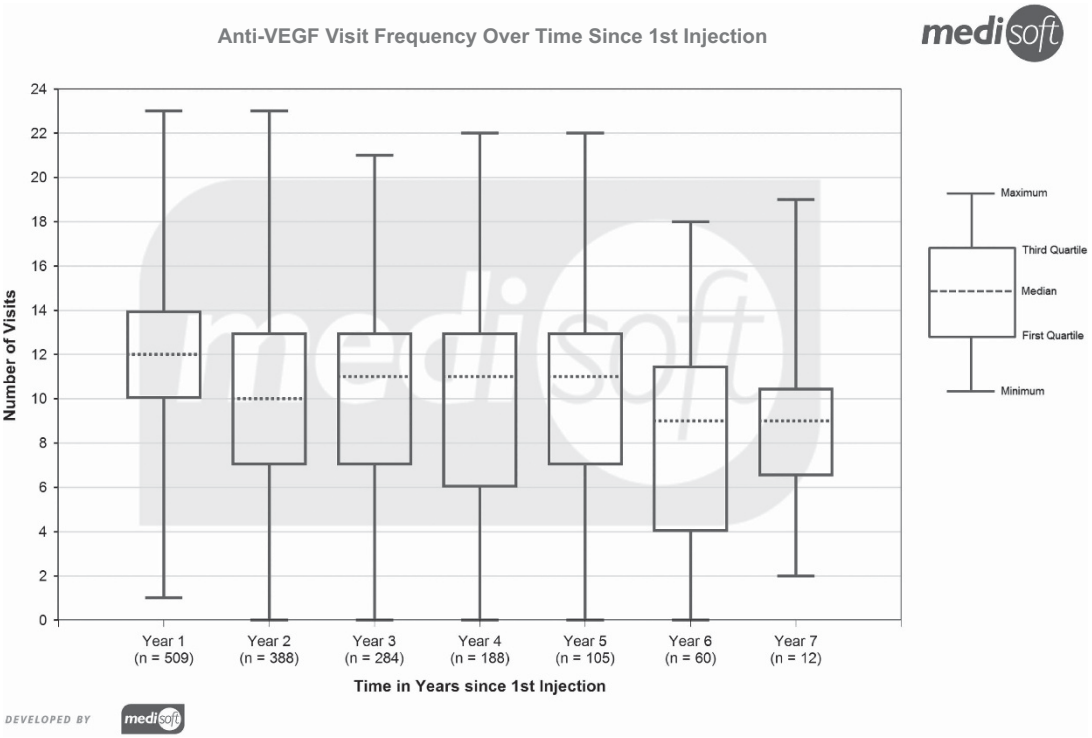

Figure 3 Anti-VEGF visit frequency over 7 years (2009–2016).

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Eye (2018) **32,** 477–479; doi:10.1038/eye.2017.211; published online 13 October 2017

Sir,
Reply to: 'Comment on: 'One-year real-world outcomes in patients receiving fixed-dosing aflibercept for neovascular age-related macular degeneration'

Thank you for your interest in our article published in *Eye*.[1]

The aim of our work[1] was to report real-world outcomes using Aflibercept in treatment-naive eyes with nAMD per the available evidence (VIEW 1&2).

In your response, you did not determine whether your cohort was composed of only treatment-naive eyes or it was a mixed group of switched and treatment-naive ones.

We believe that visual outcomes of our work are satisfactory; in the integrated analysis of the VIEW 1&2 RCTs,[2] the proportion maintaining vision (losing <15 ETDRS L) was 95% (94% in our cohort), whereas the proportion gaining >15 ETDRS L was 31% (24% in our cohort of the published work).

In our research work, classifying lesions as active/inactive (wet/dry) post loading has been of great benefit; at end of year 1, 136 eyes (53%) were inactive, whereas 119 eyes (47%) remained active. Both groups showed VA gains irrespective of the presence/absence of fluid. In both groups, the proportion maintaining vision (losing <15 ETDRS letters) was 94%. The macular status post loading was a reliable indicator of the macular status at end of year 1. Both groups received the same treatment post loading (Aflibefcept Q8W).

We would be interested in knowing the proportion of eyes in your cohort that did not require further injections post loading and what re-injection criteria were used in your centre.

In the modified IVAN protocol you implemented, it is not clear whether post-loading Aflibercept was used monthly (Q4W) or bi-monthly (Q8W). In case you used it monthly (Q4W), what would be the benefit of using Aflibercept every month if the current evidence suggested that its use bi-monthly (Q8W) was not inferior to monthly ranibizumab?[2]

Once a patient commences anti-VEG therapy, maintaining post-loading gain is a clinical challenge. In your protocol, a REACTIVE regimen was adopted in inactive eyes post loading. We carried on with a PROACTIVE protocol; bi-monthly (Q8W). It might have over-treated a proportion of eyes, but on the other hand, it did not leave the macula under the mercy of the CNV activity as you adopted post loading in inactive eyes.

When monthly treatment was discontinued and a more reactive clinician-guided approach using ranibizumab as required was used, over the subsequent 2 years