

61 Shivaji Road, Near Eves' Crossing
Meerut, UP 250001, India

Correspondence: S Agrawal
Tel: + 911212640646
Fax: + 911212650642
E-mail: dr_shishir@vsnl.com

Eye (2005) **19**, 931–932. doi:10.1038/sj.eye.6701693;
published online 17 September 2004

Sir,
Reply to S Agrawal *et al*

We are grateful to the Doctors Agrawal for their interest and comments on our paper. They comment that we have not stressed the fact that frosted branch angiitis (FBA) is 'very rarely' unilateral. In fact our extensive literature review found that 25% of 'primary' FBA cases are unilateral and that was stated in our paper.¹

The association of localized 'secondary' FBA with other retinal vasculitides was commented upon and illustrated in our paper, although the possible association with 'Indian' Eales' disease (a form of retinal vasculitis extremely common in the subcontinent, and typically presenting with substantial perivascular exudate) is interesting. We have also witnessed substantial exudate in these patients, but rather like sarcoid phlebitis, it tends to have a distinct opacity to it in comparison with the translucent frosted appearance which we have illustrated in our paper. We therefore wonder whether this is truly the same phenomenon. Clearly, there are instances of retinal ischaemia and neovascularization in patients with a frosted branch appearance. Whether all such patients should be labelled as 'Eales' disease' is open to debate, as there appears to be little agreement on the diagnostic boundaries for that disease.

There is, clearly, clinical variability to FBA, and the possibility of ischaemic complications should be borne in mind, as for any patient with retinal vasculitis.

References

- 1 Walker S, Iguchi A, Jones NP. Frosted branch angiitis: a review. *Eye* 2004; **18**: 527–533.

S Walker, A Iguchi and NP Jones

Manchester Royal Eye Hospital
Oxford Road, Manchester, M13 9WH, UK

Correspondence: NP Jones
Tel: + 44 161 276 5582
Fax: + 44 161 272 6618
E-mail: nicholas.jones@cmmc.nhs.uk

Eye (2005) **19**, 932. doi:10.1038/sj.eye.6701692;
published online 17 September 2004

Sir,
Cataract surgery after intravitreal injection of triamcinalone

I read with interest the article entitled 'Cataract surgery after intra-vitreous injection of triamcinalone acetate' by Jonas *et al.*¹ They have concluded that cataract surgery following intra-vitreous injection of triamcinalone is safe. This conclusion is based on a very small sample size of 22 cases. The posterior capsular rupture rate was calculated to be 4.5% based on one patient. I would expect the confidence interval to be large. The incidences of posterior capsular rupture in various reports have ranged between 1 and 4.8%. It is, therefore, difficult to draw any conclusions.

Secondary cataract was seen in one patient. A mean follow-up of 3.76 + 4.99 months is too short a period to reveal the true posterior capsular opacification rate.

Furthermore, with a reported incidence of postoperative endophthalmitis ranging between 0.04 and 0.2%, it is impossible to make any comments on the endophthalmitis rate based on a sample of 22 cases.

I feel that the conclusions have been overstated.

References

- 1 Jonas JB, Kreissig I, Degenring RF. Cataract surgery after intra-vitreous injection of triamcinalone acetate. *Eye* 2004; **18**: 361–364.

J Shankar

Consultant Ophthalmologist
Wrexham Maelor Hospital
Department of Ophthalmology
Croesnewydd Road Wrexham
England LL13 7TD
UK

Correspondence: J Shankar
Tel: + 44 1978 725105

Fax: + 44 1978 725829
E-mail: jai_shobitha@tesco.net

Eye (2005) **19**, 932–933. doi:10.1038/sj.eye.6701698;
published online 1 October 2004

Sir,
Reply to J Shankar

Thanking Dr Shankar for his interest in our study, we agree with him that the number of patients included in our study is too small to draw firm conclusions about the safety of cataract surgery after intravitreal injection of triamcinolone acetonide.¹ It was the purpose of the study to report about complications occurring during or after cataract surgery following intravitreal triamcinolone acetonide therapy. Since the intravitreal injection of triamcinolone acetonide has just recently been introduced into clinical ophthalmology, it may be important to have early reports about the importance of side effects of this new therapy. Since development or progression of cataract is a common side effect of intravitreal triamcinolone acetonide, and because the study did not reveal a markedly elevated rate of complications of cataract surgery following intravitreal triamcinolone acetonide, we concluded, that based on the data available so far, the cataractogenic side effect of triamcinolone acetonide may not be a major

contraindication against the intravitreal application of triamcinolone acetonide. When more patients may have received intravitreal triamcinolone acetonide for treatment of intraocular oedematous, proliferative, or neovascular diseases, future studies on larger number of patients may address the question of safety of cataract surgery following intravitreal triamcinolone acetonide.

References

- 1 Jonas JB, Kreissig I, Degenring RF. Cataract surgery after intravitreal injection of triamcinolone acetonide. *Eye* 2004; **18**: 361–364.

JB Jonas, I Kreissig and RF Degenring

Ophthalmic Department
Heidelberg University
Theodor-Kutzer-Ufer 1-3
Mannheim
Germany 68167
Germany

Correspondence: JB Jonas
Tel: + 49 621 383 2242
Fax: + 49 621 383 3803
E-mail: Jost.Jonas@augen.ma.uni-heidelberg.de

Eye (2005) **19**, 933. doi:10.1038/sj.eye.6701699;
published online 1 October 2004