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Sir,

Macular hole surgery with and without indocyanine green assistance

We read with interest the article by Slaughter and Lee[1] on macular hole surgery with and without indocyanine green assistance. Pars plana vitrectomy followed by internal gas tamponade is the key operation in the treatment of macular hole. In addition, internal limiting membrane (ILM) peeling has been suggested to improve the success rate of macular hole surgeries.[2] Indocyanine green (ICG) staining has been used to enhance the intraoperative visualization of the ILM.[2] Yet, it is still unclear as to whether the use of ICG will affect the visual outcome of macular hole surgeries because of its potential toxicity.[2–4] Slaughter and Lee have nicely addressed this important issue in their article. They have found no statistically significant difference in the mean postoperative visual acuity between two groups of patients who have undergone macular hole surgeries, one of which received ICG-assisted ILM peeling and the other received ILM peeling without ICG staining. However, we would like to discuss two important issues regarding this study.

Firstly, it has been shown in many *in vitro* studies that the toxicity of ICG to retinal cells is related to its concentration and duration of application.[3,5] Therefore, the concentrations and durations of ICG application may be crucial in causing different degrees of retinal toxicity and hence affecting the visual outcome in macular hole surgeries with ICG-assisted ILM peeling. These important parameters relating to the use of ICG have not been elaborated in the article, and we are keen to learn more about this key information.

Secondly, the postoperative visual acuity was used as one of the most important outcome measures in this study. Yet, visual acuity can be heavily affected by cataract and posterior capsular opacification, both of which are common conditions after pars plana vitrectomy and cataract extraction, respectively. The severities of these conditions in the studied cases, however, have not been discussed. We would therefore like to know whether the influence of cataract and posterior capsular opacification have been taken into account during the analysis of the postoperative visual acuity. Furthermore, LogMAR visual acuity would be a better option as compared to Snellen visual acuity since the latter is less precise especially in those patients with macular holes in whom the visions are usually poor.

While we commend Slaughter and Lee for their success in macular hole surgeries using ICG-assisted ILM peeling, we hope the above issues can broaden the discussion and deepen our understanding on how the use of ICG may affect the visual outcome of macular hole surgeries.

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Sir,

Comment on 'Quantification of the role of temporal artery biopsy in diagnosing clinically suspected giant cell arteritis'

We read with interest the recent paper 'Quantification of the role of temporal artery biopsy in diagnosing clinically suspected giant cell arteritis'.[1] We welcome the data supporting the American Rheumatology guidelines[2] and that histological confirmation from a temporal artery biopsy is not essential for a diagnosis of giant cell arteritis (GCA). There are however two points that we wish to raise:

(1) One of the aims of the paper was to 'quantify the role of temporal arteritis in diagnosing GCA'. A positive biopsy confirms the diagnosis, but a negative biopsy does not exclude it. An incidence of false negative biopsies is well acknowledged with the length of the specimen being a vital factor.[3] While it was mentioned in the discussion that there is a false-positive rate for biopsies, no information is given upon the rate of any false-negative biopsy patients in this case series. Several previous authors have followed up biopsy negative patients, diagnosing GCA in a further 5–9%. They based this diagnosis on further symptoms, signs, response to steroids, or postmortem results.[4,5] Some authors have advocated taking a second biopsy in those with a negative result, increasing the yield of positive biopsies by 3%.[6] We suggest that follow-up data are essential to identify any false-negative results. In the Greenwich scheme such false-negative biopsies should be included in the 'adverse effect' group as they may lead to delay in diagnosis and intervention.

(2) The Greenwich grading scheme is specifically assessing the clinical application of an investigation.[7] While scalp necrosis is a serious complication, for the patient it does not constitute an adverse effect on the ability of the investigation to reach the correct diagnosis.

GCA is a clinical diagnosis which continues to be challenging to confirm.

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Sir,

Disseminated paracoccidioidomycosis with chorioretinal involvement

Paracoccidioidomycosis, also known as South American blastomycosis, is a systemic granulomatous mycosis caused by the dimorphic fungus *Paracoccidioides brasiliensis*. The infection is supposed to be acquired by inhalation, with a primary localization in the lungs.[1] It is commonly an endemic disease in Latin American, but several cases have been reported in North American, Asia, and Europe, in individuals who lived in endemic areas, sometimes many years before the development of clinical manifestations.[2]