References

1 Jonas JB, Akkoyun I, Kamppeter B, Kreissig I, Degenring RF. Branch retinal vein occlusion treated by intravitreal triamcinolone acetonide. *Eye* 2005; **19**: 65–71.
2 Altman DG. *Practical Statistics for Medical Research*, 1st edn. Chapman & Hall: London, 1991.

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Sir,

Reply to intravitreal triamcinolone acetonide as treatment of branch retinal vein occlusion

We would like to thank Dr Wilkins for his interest in our study.[1] We do agree with him that the statistical basis of the study is relatively weak. As he pointed out, multiple comparisons were performed so that Bonferoni's method to correct for multiple comparisons might have been necessary. On the other hand, the number of patients in the study group was rather low ($n = 10$), despite of which the difference in visual acuity between baseline measurement and measurement at 1 month after injection was marginally significant ($P = 0.027$). Additionally, he difference between visual acuity at baseline of the study and the best visual acuity during follow-up was significant in the study group, but not in the control group. Furthermore, the study fits with other investigations on the intravitreal use of triamcinolone acetonide for a number of diseases associated with cystoid macular oedema including branch retinal vein occlusion.[2–4] In all of these studies, a decrease in macular oedema, and in most of the studies, an increase in visual acuity was observed. In conclusion, we appreciate very much Dr Wilkins' comments and consider the present study as a precursor of ongoing randomized controlled trials on intravitreal triamcinolone acetonide as treatment of retinal vein occlusions.

References

1 Jonas JB, Akkoyun I, Kamppeter B, Kreissig I, Degenring RF. Intravitreal triamcinolone acetonide as treatment of branch retinal vein occlusion. *Eye* 2005; **19**: 65–71.
2 Chen SD, Lochhead J, Patel CK, Frith P. Intravitreal triamcinolone acetonide for ischaemic macular oedema caused by branch retinal vein occlusion. *Br J Ophthalmol* 2004; **88**: 154–155.
3 Özkiris A, Evereklioglu C, Erkilic K, Ilhan Ö. The efficacy of intravitreal triamcinolone acetonide on macular edema in branch retinal vein occlusion. *Eur J Ophthalmol* 2005; **1**: 96–101.
4 Jonas JB, Kreissig I, Degenring RF. Intravitreal triamcinolone acetonide for treatment of intraocular proliferative, exudative and angiogenic diseases. *Prog Ret Eye Res* 2005 (forthcoming).

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Proprietary interest: none

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Sir,

Macrophthalmos as a long-term outcome of severe open globe injury

Long-term sequelae of open globe injuries include cataract, glaucoma, phthisis bulbi, and sympathetic ophthalmia. We present a case of a severe open globe injury in childhood resulting in macrophthalmos as an adult.

Case report

A 39-year-old man presented with gradual increased prominence of his left eye, which had suffered a corneal penetrating eye injury from a wooden stick at age 7 years and had undergone primary repair.

On examination, best-corrected visual acuities were 6/7.5 OD and perception of light OS. The appearance of the left eye is shown in Figure 1. Intraocular pressures were 16 mmHg OD and 28 mmHg OS. The left eye was aphakic.

Thyroid function tests were normal. An orbital CT scan revealed an elongated left axial length of 33 mm,