macular oedema used in the study appears to be the classic definition of CMO. Therefore, it is unclear which type of macular oedema was actually treated.

Finally, we feel that the three eyes (cases 2, 5, and 8), which developed raised intraocular pressure after intravitreal triamcinolone injection and had treatment with topical beta-blockers, should have been excluded. Topical beta-blockers have been reported to be associated with the occurrence of CMO[4] and can also affect ocular blood flow.[5] As such, the use of topical beta-blockers could be a source of potential bias in the study.

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Eye (2006) **20,** 861–862. doi:10.1038/sj.eye.6702037;
published online 12 August 2005

Sir,

Reply: Intravitreal triamcinolone as a primary therapy in diabetic macular oedema

We are grateful for Ziahosseini and associates' comments regarding our article.[1] Various studies have shown the benefit of intravitreal triamcinolone acetonide injection in patients with macular oedema secondary to several reasons.[2–6] In our article, the effect of intravitreal triamcinolone in 12 eyes of 12 patients with diabetic macular oedema that had no previous laser treatment was evaluated. This is the first article in the literature that shows the beneficial effect of intravitreal triamcinolone in eyes with diabetic macular oedema that had no previous laser treatment. Most of the patients in this series showed an increase in visual acuity compared to the baseline of the study. Parallel to the increase in visual acuity, central macular thickness decreased significantly. At 1-month follow-up, a reduction in mean central macular thickness of 40.8% from 448.6 to 265.4 μm was obtained. At the same period, no eyes lost vision and 10 eyes (83.2%) showed improvement. It is clear that the response of the treatment is dramatic.

The type of the macular oedema was clearly explained in the Material and methods according to the angiographic and tomographic findings. So fluorescein angiographic macular oedema was thought to be present if the typical oval or petaloid hyperfluorescent cystoid spaces radiating from the fovea were evident during fluorescein angiography. The optical coherence tomography examination was thought to show macular oedema if there were hyporeflective intraretinal cavities radiating from the centre of the macula in cross-sectional scans.

As Ziahosseini and associates pointed out that topical beta-blockers have been reported to be associated with the occurrence of cystoid macular oedema.[7] However, in our series topical medication was began at the 1 month follow up in patients, which developed raised intraocular pressure (cases 2, 5, and 8). Therefore, it was clear that all three patients showed anatomical and functional improvement before the topical beta-blockers.

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Eye (2006) **20,** 862–863. doi:10.1038/sj.eye.6702041; published online 12 August 2005;

Sir,

A case of occult giant cell arteritis presenting with bilateral cotton wool spots

Early diagnosis and treatment of giant cell arteritis (GCA) is important to prevent blindness in one or both eyes.[1] Occult giant cell arteritis, now a well-established entity, is defined as ocular involvement of GCA without any systemic symptoms and signs of giant cell arteritis.[1] The ocular symptoms and ischaemic lesions can be seen in a variety of combinations. We describe a case of occult GCA who presented with history of transient visual loss and bilateral cotton wool spots (CWSs).

Case report

A 59-year-old male Caucasian, who was otherwise fit, sought consultation complaining of a history of transient bilateral visual blur lasting for a few hours followed by complete resolution. Questioning specifically for systemic signs and symptoms associated with GCA at or before the onset of visual symptoms proved negative. His past medical history was unremarkable.

Visual acuities in both eyes were 6/6. His colour vision, visual fields, pupillary exam and anterior segment examination were normal. Fundus examination showed numerous elevated, whitish CWSs in both eyes with normal looking optic discs and maculae (Figure 1). The patient's superficial temporal arteries were nontender and pulsatile on both sides. His cardiovascular exam including carotid auscultation was normal.

ESR was elevated at 112 mm/h and CRP was 85 units. Fluorescein angiography showed poor and reduced filling of the retinal circulation with normal choroidal circulation and no disc oedema. He was not started on any treatment but underwent an urgent temporal artery biopsy. Histopathology showed mononuclear cell infiltration of the vessel wall, fragmentation of the internal elastic lamina, and multinucleated giant cells thus confirming the diagnosis of GCA. While awaiting his biopsy results, he re-presented with vision in his right eye having reduced to counting fingers with no obvious disc swelling. He was commenced on high-dose oral steroids and his vision improved to 6/6 with some constriction of peripheral visual field.

Comment

Occult GCA, a potential cause of blindness, is defined as ocular involvement of GCA without any systemic

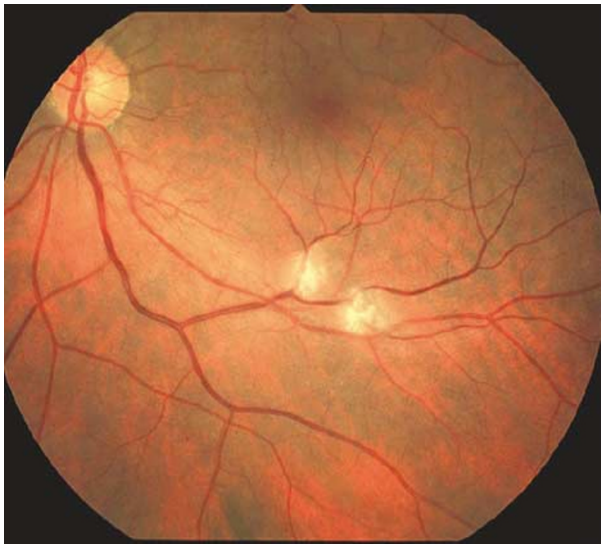

Figure 1 Fundus photograph showing CWSs, normal looking disc, and macula.