

either to maintain the post-treatment improvement in VA in those that responded, or to treat the two cases that were refractory to initial ITVA. In addition, the short follow-up time in this study (6.2 ± 1.0 months) makes it difficult to come to any conclusion about the long-term efficacy of this treatment.

Repeated intravitreal injections are not without risk — the authors did not report any injection- or corticosteroid-related complications. The risk of endophthalmitis is the most feared complication; however, varying problems from conjunctival necrosis to intraocular lens dislocation have been documented with intravitreal injection.^{7,8} In addition, progression of cataract is a well-recognised risk, and it has been suggested that this is related to the number of intravitreal injections administered to a patient.³ The situation may be further confounded as cataract surgery may aggravate macular oedema in the very eyes that have been treated with repeat injections.

The authors do not discuss their feelings on the statistically significant intraocular pressure (IOP) rise postinjection, except to mention that one eye with a persistently elevated IOP was successfully treated with topical medication. Glaucomatous eyes may not be able to tolerate the increase in IOP postinjection, even if it is within the normal range, and indeed some patients with pre-existing glaucoma may need to be treated by filtration surgery. In addition, after IVTA, that IOP may take as long as 8–9 months to return to preinjection values;⁹ this means that patients may have to be on topical treatment for a considerable time, with their attendant side effects.

The exclusion criteria of the study excluded patients if they had diabetes mellitus, presumably owing to either the potential corticosteroid-related complications associated with this intervention or because of any coexisting macular oedema that may have been a confounding factor. However, the authors mention diabetes as a risk factor for branch retinal vein occlusion (BRVO); therefore excluding these patients is excluding a large-patient group from this treatment. It does not have appeared to be part of exclusion criteria in other similar studies,⁶ and indeed ITVA used in studies to treat refractory diabetic macular oedema.¹⁰

It seems that IVTA requires further evaluation in relation to its role in the treatment of macular oedema in BRVOs.

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S Pathai

QEII Hospital, North and East Herts NHS Trust,
Ophthalmology, Howlands, Welwyn Garden City,
Herts AL7, UK

Correspondence: S Pathai,
Tel: +44 1707 365049;
Fax: +44 1438 355296.
E-mail: sophia.pathai@ukonline.co.uk

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Sir, Operating conditions for ocular surgery under general anaesthesia: an eccentric problem

Rossiter *et al*¹ have written a timely reminder of the problems that may result from Bell's reflex in the nonparalysed patient undergoing cataract surgery under general anaesthesia.

Bell's reflex can also be a problem in strabismus surgery leading to difficulties in interpretation of the

forced duction test and impeding access to the extraocular muscles.^{2,3} In a recent survey carried out in the Southwest of England, neuromuscular blocking agents were used in only 45% of children and 34% of adults undergoing strabismus surgery.⁴ The authors point out that conditions for forced duction test and ocular access may be less than ideal in a large proportion of patients undergoing strabismus surgery.

In paediatric ptosis surgery, it is necessary to set the height of the eyelid relative to the pupil under general anaesthetic.⁵ For this, the patient must be paralysed to abolish Bell's reflex at least until the levator muscle has been sutured into place.

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RA Harrad and P Stoddart

Bristol Eye Hospital, Lower Maudlin Street,
Bristol BS1 2LX, UK

Correspondence: RA Harrad,
Tel: +44 117 9284689;
Fax: +44 117 928 4891.
E-mail: r.a.harrad@bristol.ac.uk

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Sir,
Eye positions during ocular surgery

We read with interest the solutions proposed by Rossiter *et al*¹ for eccentric eye positions that develop during general anaesthesia. Ideally, the physician should recognize the abnormal eye position before starting surgery. Allowing a few minutes to elapse between

placement of a superior rectus bridle suture and the first incision should permit the intraocular pressure to normalize so that surgery can be performed safely.

As the authors indicate, a peribulbar or subtenons infiltrate of anaesthesia limited to the region around the superior rectus muscle may resolve the problem. Perilimbal traction sutures can also be helpful in providing the surgeon with more complete control of ocular movements. These are useful not only when general anaesthesia leads to eccentric eye positions but also when local anaesthesia does so.

Although the authors recommend the use of nondepolarizing muscle relaxants (NDMRs) to manage this intraoperative hurdle, we note that their use carries significant risks, as these drugs are implicated as the most common causative agents of anaphylactic reactions in anaesthetic patient populations.² Therefore, we believe that NDMRs should be considered only as a last resort after failure of local anaesthetics, traction sutures, and the tincture of time to stabilize the globe.

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A Singh and JM Stewart

Department of Ophthalmology, University of
California, 10 Koret Way, K301, San Francisco,
CA 94143-0730, USA

Correspondence: JM Stewart,
Tel: +1 415 476 0496;
Fax: +1 415 476 0336.
E-mail: stewartj@vision.ucsf.edu

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Sir,
Reply to Harrad and Stoddart

We are grateful to Harrad and Stoddart for their valuable observations made on the points raised in our paper.