lower replacement rate of Medpor-coated compared to convention tubes(3.8 *vs* 26%) is seen to be at the expense of increased conjunctival overgrowth (23 *vs* 5.7%), and the overall rate of complications is therefore in fact comparable with conventional tubes. Medpor-coated tubes fail even to meet two of the key features of an ideal tube proposed by the authors (easy to insert and removable for cleaning if necessary). They appear to have little to recommend them.

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Sir,

Reply to Pearson

We all known that the ideal bypass tube should be hydrophobic, and there should be some rigidity, good biocompatibility, and less displacement or extrusion. It can be made up of various materials. Although the pyrex tube is successful in the majority of patients in relieving tearing, the main shortcoming of a Jones tube is extrusion. Using the Medpor tube as bypass tube, an improvement or complete relief of epiphora was achieved in most cases, and the tube extrusion or displacement was not seen in our study, although the rate of tube obstruction was higher than that reported in earlier studies.

Many doctors try to find an ideal bypass tube, but unfortunately all forms of artificial tear drainage replacement may be associated with either short- or long-term complications. It is still a hard and challenging work for all ophthalmologists.

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Sir,

Correspondence to case report titled: use of pegaptanib in the treatment of vitreous haemorrhage in idiopathic retinal vasculitis

I thank the authors for this interesting case report published recently.[1] There are a few questions that need to be addressed including systemic work-up. The 'vague' nature of his presentation may have indicated a detailed medical history and referral to the physicians. Abdominal symptoms could indicate either liver or renal dysfunction and in such cases routine blood and urine tests to look for abnormal liver function tests and proteinuria as well as abdominal ultrasound are justified.

Although Eales disease is a diagnosis of exclusion, a history of contact with persons with active-treated tuberculosis and travel in 'at risk' areas needs to be elucidated.[2] Systemic tuberculosis in an important condition to exclude and immunological tests such as the Mantoux test have a tendency to give variable results.[3]

We have previous experience of a case of a 25-year Caucasian man who presented with similar ocular symptoms and signs. His disease followed an aggressive course despite immunosuppressive medical therapy, laser treatment and vitreoretinal surgery. Our patient had abnormal liver function tests and proteinuria consistent with wide-spread tissue involvement with a negative Mantoux test. Prompt referral to the physicians following medical investigations with tuberculosis immunospot test demonstrated reactivity against *Mycobacterium tuberculosis* with significant response to triple therapy.[4] We therefore suggest early referral to physicians in those patients with ischaemic vasculitis and systemic symptoms to exclude extrapulmonary tuberculosis as demonstrated in our case. Anti-VEGF agents have a specific activity to reduce oedema and inhibit angiogenesis and therefore therapy in the published case could have halted acute progression; however, it is possible that the disease process may have stabilized and resolved during the follow-up period.[5]

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Sir,

Reply to Patel and Larkin

Thank you for your interest in our case and your insightful comments. Reaching a diagnosis of Eale's disease involves systematic exclusion of known causes of retinal vasculitis.[1] Although baseline investigations are important in all cases, individually tailored diagnostic testing based on patient symptoms and signs is recommended. Furthermore, in cases of diagnostic doubt, infection may be considered more likely if, after an initial improvement with therapy, the patient's disease rapidly becomes refractory to treatment.[2]

Our case did in fact undergo an extensive systemic work-up, which was not emphasised in the study. We also referred our patient to the physicians given the unusual nature of his presenting symptoms. A complete physical examination as well as medical, contact, and travel history did not reveal any abnormalities or risk factors. In addition to routine blood and urine testing, other investigations performed included fasting glucose and lipid profile, thyroid function tests, renal and liver function tests, serum homocysteine levels, coagulation screen, vitamin B12 and folate levels, serum ACE, CRP, ESR, full autoantibody screen, serum protein electrophoresis, and 72-h Mantoux testing. Radiological investigations performed comprised a chest X-ray, abdominal ultrasound, and carotid Doppler. All investigations completed did not reveal any systemic abnormality. We agree that prompt referral to the physicians and a full contact and travel history are important in ruling out other causes of retinal vasculitis, especially in cases with systemic features (eg, fever, weight loss, and altered bowel habit). In our case, the clinical effect of adjunctive treatment with pegaptanib was evidenced by the rapid regression of disc and retinal neovascularisation with no recurrence of vitreous haemorrhage for up to 9 months.

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Sir,

Subthreshold diode micropulse panretinal photocoagulation for proliferative diabetic retinopathy

We read with interest the article 'Subthreshold diode micropulse panretinal photocoagulation for proliferative diabetic retinopathy' by Luttrull *et al*.[1]We would like to congratulate the authors for their work and cite a clarification.

The authors mention that the treatment parameters were designed to avoid the creation of clinically detectable photocoagulation lesions and that the effectiveness of subthreshold diode pan retinal photocoagulation (PRP) at this low irradiance level along with its efficacy in diabetic macular oedema is an evidence in favour of subthreshold laser in clinical practice. However, the mechanism of action of laser photocoagulation is thought to be different in these two conditions. The decrease in macular oedema is supposed to be mediated through the retinal pigment epithelium[2] for which even subthreshold energies may be sufficient. However, in proliferative diabetic retinopathy, destruction of the ischaemic retina thereby decreasing the angiogenic stimulus and improved oxygenation of the remaining retina are among the major hypotheses of the mechanism of action.[3] Keeping in mind these factors, the likely mechanism of action of subthreshold PRP stated by the authors needs clarification.

Also, is it justified to treat all the patients with the same energy levels and to titrate it with the pain threshold that has a wide variation independent of the energy required for producing a visible lesion? Titrating the energy for a visible spot and then reducing the power or the time of the laser beam will be a better method for doing subthreshold PRP, as it will provide the required subthreshold energy for a given patient and amount of retinal oedema.

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