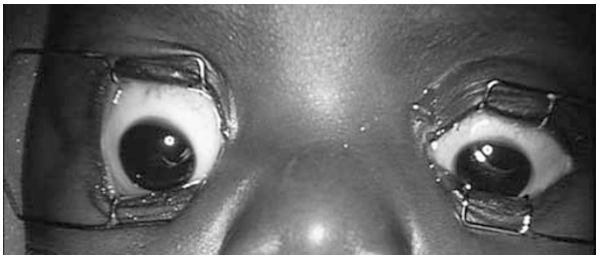

Figure 4 Significant resolution of infiltrates and proptosis after two cycles of chemotherapy.

made to start palliative whole brain radiation. He passed away 4 months later.

Comment

MS is rare and often misdiagnosed.[2,3] The incidence of a single MS is 2% in AML,[1] whereas orbital MS accounts for 1 of 250 cases.[4] An anterior chamber infiltrate might be misdiagnosed as retinoblastoma or hypopyon, resulting in delayed or improper treatment. We present this case to emphasize that MS should be considered in patients with white anterior chamber infiltrates even if previously healthy.

Conflict of interest

The authors declare no conflict of interest.

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Sir,

Reply to Spiteri Cornish and Reddy

We read with interest the paper by Spiteri Cornish and Reddy entitled 'The use of propranolol in the management of periocular capillary haemangioma – a systematic review.'[1] The authors provide an excellent review regarding the changing paradigms for the management of patients with infantile haemangiomas (IHs) and provide clear evidence as to the effectiveness of propanolol. The authors were unable to find an RCT comparing propanolol with a recognised standard or a placebo and concluded that an RCT would be beneficial but difficult to perform. The primary reason being that clinical equipoise cannot be met; given the weight of recent evidence the majority of clinicians would now be reluctant to revert to previous treatments for IHs, and therefore cannot ethically choose at random which treatment to provide.[2] An RCT in this situation will have inherent flaws with confounding factors and bias.

Glasziou *et al*[3] ask whether an RCT in this situation is actually required, illustrating similar historic milestones in medical practice where a new intervention has provided equally dramatic results. Occasionally, an RCT is not performed despite the intervention becoming mainstream practice, with examples including insulin to treat diabetes, defribrillation for ventricular fibrillati on, and sutures to repair large wounds. They go on to describe the 'rate ratio' between the signal or intervention (propanolol) and the background noise (previous treatments). This is calculated as the rate of improvement of the lesion during the new treatment divided by the rate with previous treatments. Ideally, this ratio should be over 20, that is treatment with propanolol should increase the rate of improvement by over a factor of 20 when compared with a control that allows for bias and other confounding factors.

Clearly, the efficacy of propanolol is not disputed and issues regarding adverse effects should now be monitored using long-term data collection in the form of either a prospective database or registry. Such observational data will highlight rarer treatment complications and long-term effects. The optimal mode, dose, and duration of treatment of propanolol are yet to be defined and well-designed RCTs in this context would certainly be of benefit.

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Sir,

Response to Dr Norris and Dr McCulloch

We thank Dr Norris and Dr McCulloch[1] for their interest in our paper[2] and for their very informative comments. We fully agree with them on the issues and potential difficulties in designing a randomised controlled trial (RCT) when one of the modalities of treatment (oral propranolol) has a very high 'success' rate in published literature. We have highlighted this in our paper under the subheading 'areas for future research'. We collude with the authors on the need for an RCT to further explore dosage and duration of oral propranolol therapy and to monitor adverse effects.

Conflict of interest

The authors declare no conflict of interest.

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Sir,

Comment on 'Silicone oil removal after rhegmatogenous retinal detachment: comparing techniques'

We would like to commend Tan *et al*[1] on their study comparing two methods of silicone oil removal. The paper succinctly describes different methods in removing silicone oil and its different advantages. However, it fails to convince the readers that two port removal is more advantageous as stated in the paper. First, there were only 10 cases which had less than 2 months of tamponade compared with 133 cases with longer than 2 months tamponade. This disproportionate number does not allow for accurate statistical analysis. The numbers also do not add up to the total 147 cases described. Also, 43% of 10 eyes is 4.3 eyes and it is difficult to understand how 0.3 eyes can have redetachment. Furthermore, there lacks a multiple regression analysis of the various factors described such as presence of PVR in the two groups and repeat surgeries in the two groups as it is well known that these factors influence the success of retinal detachment surgery. There is also a discrepancy where the authors have excluded patients with macular pucker before extraction, but further described 38 of 52 (73%) of 3 port extraction cases undergoing membrane peeling. The authors have also stated two advantages of the three port technique: (1) ability to perform extensive internal search and (2) improved oil removal. Herbert *et al*[2] reported retinal redetachment rate of 21% following removal of silicone oil with internal search. This is not significantly lower than other published rates of redetachment following oil removal. However, the paper also describes the identification of new retinal breaks in 35% of eyes (only 4% by Tan *et al*[1]). With this high incidence of new break identification, one would have thought that the retinal redetachment rate for the two port technique would be significantly higher than the three port technique. Tan *et al*[1] found a higher redetachment rate (21%) in the three port technique compared with the two port technique (14%). In summary, from the data provided it is difficult to conclude that the two port technique is more cost-effective.

Conflict of interest

The authors declare no conflict of interest.

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