vitrectomy and ERM removal; thus, patients having ERM should be given the benefit of early surgery.

Conflict of interest

The authors declare no conflict of interest.

References

1 Morales AG. Coats' disease. Natural history and results of treatment. *Am J Ophthalmol* 1965; **60**: 855–865.
2 Rishi P, Rishi E, Uparkar M, Sharma T, Gopal L, Bhende P *et al*. Coats' disease: an Indian perspective. *Indian J Ophthalmol* 2010; **58**(2): 119–124.
3 Shields JA, Shields CL, Honavar SG, DeMirci H. Clinical variations and complications of Coats' disease in 150 cases: the 2000 Sanford Gifford memorial lecture. *Am J Ophthalmol* 2001; **131**: 561–571.
4 Shukla D, Chakraborty S, Behera UC, Kim R. Vitrectomy for epimacular membrane secondary to adult-onset coats' disease. *Ophthalmic Surg Lasers Imaging* 2008; **39**(3): 430–431.

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Sir,

Novel technique for silicone oil retention suture with secondary auto capsulotomy of fibrin membrane

Silicone oil is toxic to the cornea causing endothelial failure and band keratopathy.[1] In traumatic aniridia and aphakia, there lacks a barrier for silicone oil between the posterior and anterior chambers. Therefore, if retinal surgery is also required, silicone oil tamponade may cause the cornea to decompensate unless an artificial barrier can be constructed. We report a novel technique in a patient following globe rupture.

Case report

A 43-year-old male who had previous penetrating keratoplasty for keratoconus endured blunt trauma to his left eye. He had total iris loss and required a repeat penetrating keratoplasty and lensectomy due to the globe rupture. Three weeks later, he had a total retinal detachment with severe proliferative vitreoretinopathy (PVR). He underwent pars plana vitrectomy, retinectomy, PVR membrane peel, laser, and silicone oil tamponade. Before silicone oil injection, 360-degree conjunctival peritomy was performed, and an artificial barrier was formed using a continuous 10/0 prolene suture (Ethicon W1713, Somerville, NJ, USA) placed 2.5 mm from the corneal limbus (Figure 1a).

Within 2 months, he developed a membrane at the level of the retention suture, seperating the silicone oil from the anterior chamber. Laser capsulotomy was initially planned, but he subsequently spontaneously developed a central opening within the membrane (Figure 1b). His retina remained flat under oil, and visual acuity at 4 months follow-up was counting fingers.

Discussion

Retention sutures are effective in preventing corneal decompensation in aniridic eyes requiring silicone oil tamponade.[2] This is because of the surface tension of silicone oil and its propensity to stay as a single bubble within the vitreous cavity. The method described above allows for one continuous suture to be used in forming the barrier, and is an alternative to the previously described technique using multiple sutures. It is not known if the hexagonal shape is better than others at stimulating peri-silicone proliferation and membrane formation,[3] the rate of which may also vary between patients and with topical steroid use. In our case, an opening in the membrane formed spontaneously, but in others, laser capsulotomy may be required.

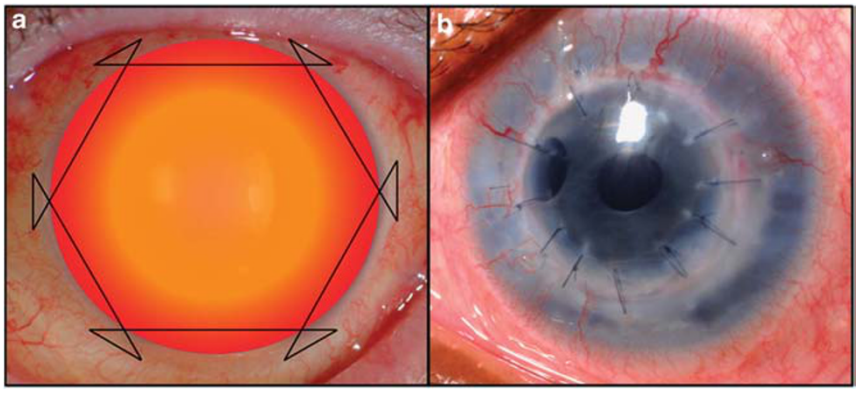

Figure 1 (a) Schematic diagram of hexagonal silicone oil retention suture and (b) Opening in peri-silicone oil membrane present 4 months following surgery.

Conflict of interest

The authors declare no conflict of interest.

References

1 Sternberg Jr P, Hatchell DL, Foulks GN, Landers III, MB. The effect of silicone oil on the cornea. *Arch Ophthalmol* 1985; **103**(1): 90–94.
2 Ronald C, Gentile RC, Eliott D. Silicone oil retention sutures in aphakic eyes with iris loss. *Arch Ophthalmol* 2010; **128**(12): 1596–1599.
3 Asaria RHY, Kon CH, Bunce C, Sethi CS, Limb GA, Khaw PT *et al*. Silicone oil concentrates fibrogenic growth factors in the retro-oil fluid. *Br J Ophthalmol* 2004; **88**: 1439–1442.

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Sir,

Interval censoring for survival curves when reporting the results of glaucoma surgery

I read with interest the study by Anand and Wechsler[1], reporting the outcomes of deep sclerectomy in eyes with previous surgery. In common with many studies in the literature, however, they have failed to take account of interval censoring when plotting survival curves.

Interval censoring occurs when we do not know the exact time an event occurs, but only the interval in which it occurs. This is relevant to failure in glaucoma surgery because when we detect that the intraocular pressure has risen above a predetermined level at follow-up, we do not know exactly when this occurred, only that it occurred in the interval between two clinic visits.

This effect must be taken into account when plotting survival curves.[2,3] By failing to take it into account, the survival curve is effectively shifted to the right and the apparent survival is increased.

Many statistical packages do not allow for the analysis of interval-censored data. However, the freely available statistical package R has a survival plotting function that can correctly account for such data.[4]

For reference, my instructions for plotting an interval-censored survival curve using R are presented here, for those who want to plot interval-censored survival curves in their research.

Create a Microsoft Excel spreadsheet with the headings 'lefttime', 'righttime', and 'myevent' in cells A1, B1, and C1, respectively. Then enter survival data into each row (ie create a 'life table').

Righttime = the clinic visit where the patient 'failed' (time is usually measured in months after surgery; leave blank if the patient did not fail). Lefttime = the clinic visit immediately before the visit where the patient failed, or the final follow-up visit if the patient did not fail. Myevent = '0' if they have not failed and '3' if they have failed.

Save this as a .csv file in the R working directory—for example survival.csv. Open up the R console and type the following:

```
library(survival)
data1 <- read.csv(''survival.csv'', header = TRUE)
mysurv <- with(data1, Surv(lefttime, righttime, myevent, ''interval''))
```

To plot the survival curve type:

```
mysurvfit = survfit(mysurv ~ 1)
plot(mysurvfit)
```

This will plot an interval-censored survival curve with 95% confidence intervals for the data in the life table.

Conflict of interest

The author declares no conflict of interest.

References

1 Anand N, Wechsler D. Deep sclerectomy with mitomycin C in eyes with failed glaucoma surgery and pseudophakia. *Eye* 2012; **26**: 70–79.
2 Zhang Z, Sun J. Interval censoring. *Stat Methods Med Res* 2010; **1**: 53–70.
3 Dulku S. Trabeculectomy success rates. *Ophthalmology* 2012; **119**: 2194–2195.
4 R Development Core Team. *R: A Language and Environment for Statistical Computing*. R Foundation for Statistical Computing: Vienna, Austria, 2010, ISBN 3-900051-07-0. http://www.R-project.org (accessed 29 March 2012).

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Sir,

Comment on 'Deep sclerectomy with mitomycin C in eyes with failed glaucoma surgery and pseudophakia'

We read with interest Anand and Wechsler's recently published article on deep sclerectomy with mitomycin C[1] and would like to congratulate the authors on their excellent outcomes. We have retrospectively analysed the long-term outcomes of trabeculectomies with selective 5-fluorouracil (5-FU) enhancement performed by a single district general hospital ophthalmologist (author APM) and would like to share our results as they are remarkably similar.