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Sir,

Reply: Pseudoexfoliation syndrome and cardiovascular disease: studies must control for all cardiovascular risk factors

We thank Dr Yusuf for his comments[1] regarding our article.[2]

In this study, aorta-renal vasculature was examined in patients with pseudoexfoliation syndrome (PEX). In addition to these evaluated parameters, intrarenal vasculature and renal parenchyma were examined by Doppler ultrasonography and serum urea, blood urea nitrogen, creatinine, urinary microalbumin and creatinine clearance were analyzed. These parameters were used in another study for evaluation of the renal function in patients with PEX. In PEX and control groups, urinary microalbumin levels were 5.8 ± 22.7 mg/24 h and 2.7 ± 6.0 mg/24 h, respectively ($P = 0.441$). Microalbuminuria was not observed in both groups. In the light of this information, we think that urinary microalbumin levels had no effect on the results of our study.

Serum cholesterol levels were not investigated in this study. On the other hand, all subjects were examined about history of cardiovascular diseases and the patients with cardiovascular diseases were excluded from the study. Heterozygous familial hypercholesterolemia is among the most common inborn errors of metabolism and occurs in approximately one in 500 persons; affected individuals can usually be identified from birth by elevated levels of plasma LDL cholesterol.[3] Heterozygous familial hypercholesterolemia is accelerated vascular disease, especially coronary artery disease.[4] There was a significant association between total plasma cholesterol level and coronary artery disease incidence.[5] Although the exclusion of the serum cholesterol data might seem like a limiting factor of the study, we consider that vascular disease risk associated with hypercholesterolemia may be eliminated because of the patients with coronary artery disease were excluded from the study.

We also believe that a prospective longitudinal cohort study should be performed in patients with PEX to determine the relative risk of serious cardiovascular events in relation to other risk factors.

Conflict of interest

The authors declare no conflict of interest.

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Sir,

Lubricants to prevent recurrent corneal erosion: an error in the Cochrane review

We have noticed an error in the Cochrane review 'Interventions for recurrent corneal erosions' published in September 2012 (and in the previous version published 2009).[1]

In 1999 Eke and colleagues[2] published the unexpected finding that following corneal abrasion with a fingernail, the use of topical lubricants increased the risk of

recurrent erosion syndrome. (Despite this it remains common clinical practice to prescribe lubricants.) The Cochrane review cites this as the only study addressing the use of lubricants to prevent recurrent erosion syndrome.

However, there appears to be a discrepancy in how they cite Eke's findings. In the Cochrane review's abstract and results section, the authors correctly cite the Eke paper as indicating that lubricants carry an increased risk of recurrent erosion. However in the discussion section there appears to be an error: the authors state that the Eke paper indicates that lubricants *reduce* the risk of recurrent erosion.

We call for a correction in the Cochrane review, to emphasise the unexpected evidence that lubricants do not reduce the risk of recurrent erosion syndrome, but rather increase it.

Conflict of interest

The authors declare no conflict of interest.

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Sir,

Response to Spitzer *et al*

I am grateful to Spitzer *et al*[1] for pointing out this error in the Cochrane review of interventions for recurrent corneal erosions.[2] This review was able to cite only one study[3] that looked at a 'prophylactic regime to avert the development of recurrent corneal erosion' following traumatic corneal abrasion. The abstract includes a correct interpretation of our paper, but the body of the publication misrepresents our findings. The reviewers correctly state that we found 'the addition of lubricating ointment at night [for 2 months] to the standard therapy… resulted in significantly fewer patients with no or minimal symptoms of recurrent corneal erosion at three months'.[2] However, they fail to mention that this was because there were significantly more patients who had mild or moderate symptoms at this time (50% in the additional ointment group, 10% in the standard therapy group),[3] and thereby their Summary draws the opposite conclusion to our own. We had concluded that there was a 'significantly higher prevalence of recurrent symptoms in the 'additional nightly ointment' group ($P = 0.016$)'.[3]

In our paper,[3] we stated that we were surprised by the higher prevalence of recurrent symptoms in the 'additional nightly ointment' group, as we had expected ointment to reduce symptoms. We speculated that ointment might actually interfere with healing of corneal abrasions. We had intended to carry out a further prospective study, to compare ointment, drops, and bandage lenses in the initial management of traumatic corneal abrasion. This never happened, mainly because I moved to a hospital that does not have an open-access eye casualty. I encourage colleagues who do work in such units to carry out this simple study: the results would be of great help to patients who suffer from this common and disabling condition.

In my experience, it is common for authors to mis-quote other papers, and I always encourage my trainees to read an original source in full. Spitzer has highlighted a significant misquotation, in that a Cochrane review has found only one paper to cite, but erroneously draws the opposite conclusion to that of the original researchers. I agree that, in this case, a published clarification would be desirable.

Conflict of interest

The author declares no conflict of interest.

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1 Spitzer D, Habib A, Imonikhe R, Raina J. Lubricants to prevent recurrent corneal erosion: an error in the Cochrane review. *Eye* 2013; **27**(11): 1329–1330.
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Sir,

Interventions for recurrent corneal erosion: a Cochrane Systematic review

We would like to thank Dr Spitzer and colleagues[1] for identifying the need for a correction to our Cochrane