Sir, Safety of Brilliant Blue G

We are grateful to Shukla and Singh¹ for their comments about our paper.² We acknowledge their criticisms and apologize for the errors in the references that they pointed out. We had no intention of suggesting that Ocublue Plus (OP) was not approved in the European Union (EU) but, to the best of our knowledge at the time of the study in 2010, only Brilliant Peel (BP) was available in the EU for commercial use. In our study, we compared the neurosensory retinal thickness between OP and controls in the same animal. No direct comparison was done between OP and other groups like BP and ICG. The reduction in neurosensory retinal thickness in the OP group was significant when compared to the controls. This cannot be extrapolated to compare differences between OP and BP.

As most of the previous publications on OP came from the institution that is commercially producing and marketing it, we felt that it was important to try to independently compare OP with other commercially available products being used to stain the internal limiting membrane during vitreoretinal surgery. We acknowledge the limitations and shortcomings of this laboratory study but would continue to encourage more work to be done in this field to ensure the safety and efficacy of such products post approval. In light of their comments, we agree that our conclusion that OP caused reduction of the RGC density is not accurate.

Conflict of interest

The authors declare no conflict of interest.

References

- 1 Shukla D, Singh J. On the safety profile of Ocublue Plus (BBG 0.05%). *Eye* 2014; **28**: 1147.
- 2 Ooi YL, Khang TF, Naidu M, Fong KCS. The structural effect of intravitreal brilliant blue G and indocyanine green in rats eyes. *Eye* 2013; **27**: 425–431.

KCS Fong, YL Ooi and TF Khang

University of Malaya, Kuala Lumpur, Malaysia
E-mail: fongcsk@yahoo.co.uk

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Sir, Resolution of persistent pigment epithelial detachment secondary to polypoidal choroidal vasculopathy in response to Aflibercept

Since Aflibercept became commercially available, there have been several publications describing favourable early experience, particularly in cases previously refractory to other anti-vascular endothelial growth factor (anti-VEGF) and cases with persistent pigment epithelial detachment (PED).^{1–5} However, there is very little clinical experience of Aflibercept in polypoidal choroidal vasculopathy. We present our favourable experience with Aflibercept in the treatment of persistent PED after photodynamic therapy (PDT) combined with Ranibizumab.

Case report

A 64-year-old Chinese lady who first presented with submacular haemorrhage from an extrafoveal PCV in 2010. The lesion was successfully lasered with resolution of blood and vision returned to 6/6. A recurrent episode of subretinal haemorrhage occurred 2 years later, which resolved with focal laser and three intravitreal Ranibizumab injections. Vision recovered from 6/18 to 6/9. In March 2013, recurrent fluid developed, which coincided with vision dropping to 6/15 (Figures 1a and b). A cluster of polyps was seen emanating from the laser scar (Figure 1c). Combination therapy with full fluence PDT, (spot size 3800 μ m) and Ranibizumab (0.5 mg) was performed. However, at 1 month review, vision did not improve and a new PED had developed (Figure 1d). A further Ranibizumab injection was given, which resolved the subretinal fluid 1 month later, but the PED persisted (Figure 1e). The patient was acutely aware of distortion, with a visual acuity of 6/12. Aflibercept became available at this time. After the first Aflibercept injection (2 mg), vision remained at 6/12 although patient reported subjective improvement (Figure 1f). Noticeable flattening of the PED was noted after further Aflibercept monthly injections (Figures 1g and i). Repeat angiogram showed significant regression of polyps (Figure 1h). Vision was 6/7.5 at last follow-up.

Comment

This case shows promising results of intravitreal Aflibercept in the treatment of PCV refractory to the combination PDT and Ranibizumab. The benefit of initial three monthly loading was clearly demonstrated as significant flattening of the PED only occurred after the second and third injections. The resolution of polyps on ICGA was likely to be due to the combined effect of PDT and anti-VEGF therapy.

Figure 1 (a) The colour fundus photograph shows two areas of previous laser to extrafoveal polyps (arrows). (b) Optical coherence tomography scan through the fovea showed the presence of subretinal fluid. (c) Indocyanine green angiography (ICGA) performed showed a cluster of polyps emanating from the area lasered previously. Intravitreal ranibizumab with Photodynamic therapy was performed using a spot size of 3800 μ m (dotted circle). (d) At 1 month review, a new pigment epithelial detachment (PED) had developed, and persistent subretinal fluid was apparent. (e) One month after a further intravitreal ranibizumab injection was given, there was reduction in subretinal fluid, but the PED persisted. (f) One month after first aflibercept injection, foveal contour improved, but PED persisted. (g, i) Progressive flattening of PED was observed after the second and third monthly dosing of aflibercept. (h) Repeat ICGA showed significant regression of the cluster of polyps.