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Sir,
Response to Dr Clearkin

We thank Dr Clearkin for his comments[1] on our recent editorial with regard to the implementation of shingles vaccine in UK.[2] Our intention was to comment on the potential benefits of vaccination rather than provide an overview of evidence-based practice for the management of zoster-associated anterior uveitis.

However, we mention in the paper the use of topical steroids in the treatment of zoster-associated anterior uveitis, a practice that is recommended in the current *Oxford Handbook of Ophthalmology*.[3]

This is a contentious area and differences of opinion remain in the use of topical steroids in the treatment of zoster-related anterior uveitis. It is sadly not as clear cut as Clearkin's comments would suggest. The papers cited from Marsh and Cooper[4] and McGill and Chapman[5] refer to studies evaluating topical acyclovir *vs* topical steroid in the treatment of zoster keratouveitis and not just zoster-related anterior uveitis. Although they show a statistical benefit of topical antiviral over topical steroid in the management of keratitis, the data for those with anterior uveitis did not show a statistical benefit. The authors themselves agree that there remains a role for topical steroids in patients who do not respond adequately to topical acyclovir.[4,5]

As Clearkin mentions, Herbort *et al*[6] show that the use of oral acyclovir in the treatment of early zoster is beneficial, has extensive external evidence to support, and has been generally adopted as best practice by all. Many other authors[7–9] however continue to advocate the use of topical steroids in the treatment of zoster-related anterior uveitis. We therefore feel this area will remain open for discussion until more robust data, specific for zoster-associated anterior uveitis, are available.

We would however agree about Clearkin's comments on the potential benefits of the use of gabapentin for pain control in post-herpetic neuralgia.[10]

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Sir,
Vitreoretinal surgery for inadvertent intralenticular Ozurdex implant

We read with interest the recent report by Chhabra *et al.*[1] We would like to share a similar rare case that required early vitreoretinal intervention. In our case, a 62-year-old with left branch retinal vein occlusion and macular oedema underwent an Ozurdex injection in another eye unit. The implant was inadvertently injected into the crystalline lens, and the patient presented 2 weeks later