Conflict of interest

The authors declare no conflict of interest.

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Sir,
Comment on 'The effect of erythropoietin on the severity of retinopathy of prematurity'

We read with interest the article 'The effect of erythropoietin on the severity of retinopathy of prematurity'.[1] Even if the results are interesting, we have a few concerns and comments. The use of sedatives to screen all the babies for ROP is surprising and can be risky for these vulnerable infants.[2] The babies with stage 3 ROP were treated when they reached threshold stage despite ETROP recommendation[3] to treat babies, at high risk, prethreshold, and beyond. This questions the efficiency of the treatment strategy followed in the study. The images of the infants needing treatment were reviewed by another examiner before treatment probably implies that the findings of the screening physicians required reconfirmation. In such a case, babies labelled with severe ROP after erythropoietin injection should also have been reconfirmed by a retina specialist. Although the indication to give erythropoietin was under the discretion of the paediatrician, some details like baseline haemoglobin concentration and platelet count at the time of erythropoietin injection would have been more informative as they are known to affect the severity of ROP independent of erythropoietin. Reports say that effect of erythropoietin on ROP depends whether it was given at early or late post-natal life.[4] So a similar division in the study could have given extra information.

The cumulative dose of erythropoietin received by neonate with mild ROP (3200 units) was more than those with severe disease (2750 units). To establish erythropoietin as a contributory cause, it is important for the cause to not only have statistical significance but also alter the effect on altering the cause with a proven dose–response relationship, which the study fails to show.

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Sir,
Comment on 'Photocoagulation guided by wide-field fundus autofluorescence in eyes with asteroid hyalosis': single and double pass of light in the ocular media

I enjoyed reading the case report from Ogino *et al*.[1] I agree that examining and treating patients with concurrent asteroid hyalosis and proliferative retinopathy is a significant challenge. I also agree that autofluorescence images and fluorescein angiography are much less affected by the presence of the vitreous opacities than fundoscopy and colour images.

The given reason that the wavelengths of light used to obtain these images are less affected by the asteroid bodies is however incorrect.

During biomicroscopy or colour photography light passes through the ocular media, reflects from the RPE/choroid, and exits through the ocular media into the imaging system. This is known as a double pass and is a multiplication not addition. The image quality is reduced by 'media-squared' not 'media-doubled'.

In FFA and AF the light exiting the eye has its origin entirely in the posterior layers of the globe. The incident light is absorbed and molecule-bound electrons are raised into higher energy levels. The electrons make a transition to an intermediate energy level and new light