Other authors have used the term 'myopic traction maculopathy', but in our opinion this name is equally confusing.⁵

We thus propose the term 'myopic ectatic retinopathy' as an appropriate term in order to describe the clinical situation that occurs in some myopic patients leading to stretching of retinal layers at the posterior pole of the eye. We think the proposed term is literally and functionally more accurate, denoting the mechanical background of the situation, while at the same time it is distinct and non-confusing. It can also be included under the broader category of 'traction retinopathies' together with vitreoretinal traction syndrome and tractional retinal detachment.

Conflict of interest

The authors declare no conflict of interest.

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**Sir,
Reply: 'Myopic foveoschisis: an ectatic retinopathy,
not a schisis'**

We thank Tsilimbaris *et al*¹ for their comments on the appropriateness of the term 'myopic foveoschisis' to describe the condition that is characterized by the separation of neural retina layers associated with high myopia and posterior staphyloma. They have proposed the term 'myopic ectatic retinopathy' as a more literal and functionally more accurate descriptor of the condition to avoid the use of the word 'schisis', which may be misleading because it is also used to describe other

conditions where there is separation of neural retina layers without the presence of staphyloma.²

Using the word 'ectatic' for this condition would imply that we are fairly certain about the pathogenesis and mechanistic factors that underlie its development and progression. However, this is not the case, unfortunately, as our review of the literature has shown. There are several theories ranging from vitreous traction to sclerosing changes of retinal vessels to progression of staphylomas as possible etiological factors. Therefore, it is likely to be multifactorial in nature—hence the success reported with different procedures that address either the vitreous traction factor using vitrectomy, peel plus tamponade or the scleral ectasia factor using posterior buckling techniques.

In the absence of a good understanding of underlying pathogenesis, it is probably best to use purely descriptive names rather than mechanistic terms. The use of descriptive terms, even though similar, do not necessarily cause confusion as long as they are widely accepted as differentiating terminology, for example, postoperative pseudophakic cystoid macular edema (Irvine–Gass syndrome) vs cystoid macular edema associated with posterior uveitis in a phakic patient. The introduction of too many mechanistic or pathogenetic terms in the absence of clear understating of etiology can in fact cause more confusion, for example, serous chorioretinopathy vs central serous retinopathy vs serous choroidopathy. The confinement to broad descriptive terms can enhance communication and reduce confusion without committing to any presumption about etiology until it is better understood. This approach is probably best illustrated by the recent advances in the understanding of mactel₂, a condition initially described and classified, using descriptive nomenclature, by Don Gass as bilateral, idiopathic acquired juxtafoveal telangiectasis (Group 2A) and as distinctly different from unilateral, congenital parafoveal telangiectasis (Group 1A; Gass,³ pp 504–506 vs 127–128).

Finally, it is worthy to note that for myopic foveoschisis associated with a staphyloma that is associated with outer layer macular detachment, Don Gass also descriptively included the additional observation (before the advent of OCT) that the retinal profile was concave rather than convex in shape, thereby differentiating it from rhegmatogenous detachments with recruitment of subretinal fluid that is associated with posteriorly located breaks and macular holes in myopic eyes.

Conflict of interest

The authors declare no conflict of interest.

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Sir, MEK inhibitors: a new class of chemotherapeutic agents with ocular toxicity

We read with interest Duncan *et al*'s¹ article published in the August edition of the *Eye*.

We have made similar observations in patient's taking R05126766 (a combined RAF and MEK inhibitor) for advanced stage cancers and found retinal changes to be common.

MEK inhibitors act upon the mitogen-activated protein kinase (MAPK) pathway, which is upregulated in a number of cancers. R05126766, the first-in-human combined RAF/MEK inhibitor, offers dual inhibition on the MAPK pathway and superior cascade blockage.^{2,3} Ocular toxicities were reported in up to 50% of patients.²

Despite increased use of MEK inhibitors,^{3,4} there has been limited ophthalmic literature. We would like to share our experiences regarding them.

We retrospectively analysed clinical notes for a 15-patient cohort, commenced on R05126766 monotherapy, as part of an ongoing prospective phase 1/2 trial. Each patient had baseline ophthalmic assessment and at least one follow-up while taking R05126766. The examinations were performed by the same consultant ophthalmic specialist (PU).

Retinal changes, including central serous retinopathy and pigment epithelial detachments were seen in eight

patients. Six patients were symptomatic, describing blurred vision, scotomas, and two patients described a blue discolouration. We also noted that 75% of the patients who developed ocular toxicity complained of a rash, compared with only one patient (14%) without ocular toxicity. Please see Table 1 for results summary.

The onset of symptoms varied from 1 day to 4 months. Conclusive follow-up was not achieved because of poor patient health, with quite a number dying before resolution of their symptoms.

We have observed a high incidence of retinal pathologies in this small group of patients taking combined RAF/MEK inhibitors. We agree with the conclusions made by our colleagues Duncan *et al* and would recommend that baseline ophthalmic assessment with optical coherence tomography should be obtained in all patients before commencing MEK inhibitor chemotherapy.

As MEK inhibitors continue to be developed,^{3,4} we predict an increased incidence of associated ocular toxicities, which may be more common than first realised. It is important, therefore, that general ophthalmologists are aware of these drugs. Further understanding of the aetiology and management of complications is needed.

Conflict of interest

The authors declare no conflict of interest.

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Table 1 Summary table showing results for the eight patients

Case no	Age	Sex	Type of cancer	Signs	Confirmed on OCT	Onset	Rash
1	57	M	Colorectal	Bilateral CSR	Yes	1 Month	Yes
2	50	M	Adrenal	Bilateral CSR	Yes	Day 1	Yes
3	62	M	Metastatic melanoma	unilateral CSR	Yes	1 Week	Yes
4	54	M	Metastatic melanoma	Bilateral PED	No	2 Months	Yes
5	64	M	Metastatic colorectal	Unilateral PED	No	4 Months	No
6	40	F	Metastatic melanoma	Unilateral RPE changes	Yes	1 Week	Yes
7	58	M	Colorectal	Unilateral PED	No	1 Week	Yes
8	64	F	Metastatic melanoma	Unilateral PED	Yes	1 month	No