



**Figure 2** Corneal fluorescein staining (white) using fluorescein filters at presentation (above) and after 2 months of QDS FAB therapy (below).

### Conflict of interest

The authors declare no conflict of interest.

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### Sir, Do we screen very premature babies too early for retinopathy of prematurity?

Retinopathy of prematurity (ROP) is a disorder of retinal vascular development in preterm infants. ROP accounts for approximately 3% of all cases of severe visual impairment and blindness in childhood in the UK.<sup>1</sup> Early diagnosis and treatment can largely prevent visual loss caused by ROP. Screening examinations are known to cause significant discomfort and distress.<sup>2,3</sup>

The most recent UK Retinopathy of Prematurity Guideline was introduced in May 2008.<sup>4</sup> All babies born less than 32 weeks gestational age (GA) (up to 31 weeks and 6 days) or less than 1501 g birth weight should be screened for ROP. Infants born before 27 weeks GA (ie up to 26 weeks and 6 days) should have their initial ROP screening examination at 30–31 weeks postmenstrual age (PMA).

We reviewed the screening records of all premature babies born prior to 27 weeks (26 weeks and 6 days) GA and subsequently screened at 30 weeks (up to 30 weeks and 6 days) in a single unit in Edinburgh between February 2005 and February 2015. Sixty-eight infants were identified.

Forty-four of the examined infants had *tunica vasculosa lentis*/persistent fetal vasculature, which limited the fundal view. Five screening examinations had to be postponed owing to absence of any fundal view.

Three babies had ROP. Two had Zone II Stage 1 with no plus disease and one had Zone II Stage 3 with no plus disease. Treatment was not required for any infant at the time of this initial examination. All infants were followed up within a 1 to 2 week interval until they met the termination of ROP screening criteria or developed ROP and received treatment; according to the criteria set out in the guidelines.

We suggest that the UK screening guideline could be revised to a first ROP screening examination for premature babies born prior to 27 weeks to be performed at 31 weeks (31 weeks and zero days to 31 weeks and 6 days) PMA. This revision would align the UK screening protocol with the current American Academy of Pediatrics/American Academy of Ophthalmology/American Association of Pediatric Ophthalmology and Strabismus recommendation for 22–27 weeks GA infants to initiate screening at 31 PMA.<sup>5</sup> Data from other neonatal units in the UK are needed to add confidence to this suggestion.

This change would allow premature babies an additional week before their first examination to stabilise without compromising their safety.

#### Conflict of interest

The authors declare no conflict of interest.

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#### Sir, Treat and extend regimen with aflibercept for choroidal neovascularization in angiod streaks

Choroidal neovascularization (CNV) secondary to angiod streaks (AS) is a cause of important vision loss. The use of antivascular endothelial growth factors to treat CNV due to AS is well described. Until now, only experience with bevacizumab and ranibizumab had been reported to be an effective option of treatment.<sup>1</sup> Recently, Vaz-Pereira *et al* reported in *Eye* the first two cases of CNV due to AS in which intravitreal aflibercept was used as primary treatment with *pro re nata* (PRN) regimen.<sup>2</sup> We suggest the option of treat and extend regimen for this type of cases. We present the first case of CNV in AS in which intravitreal aflibercept was used following a treat and extend regimen with a follow-up period of 1 year.

#### Case report

A 60-year-old woman came to the emergency room with metamorphopsia in her left eye (LE). She had the medical antecedent of CNV secondary to AS in her right eye (RE) treated with 11 intravitreal injections of bevacizumab following a PRN regimen and a bad evolution. A complete ophthalmic examination was done. Her best corrected visual acuity (BCVA) was 20/200 in RE and 20/25 in LE. The anterior pole did not show any abnormality. The intraocular pressure was 15 and 17 mmHg, respectively. Funduscopy showed a disciform membrane in RE and AS in both eyes. Optical coherence tomography (OCT) revealed subretinal fibrosis with distortion of the foveal anatomy in RE and an incipient CNV in LE (Figure 1) confirmed by fluorescein angiography. Intravitreal aflibercept was injected in LE, one injection a month during 3 months. BCVA in LE improved to 20/20 and also OCT. After the good response in LE and bad evolution in RE, a treat and extend regimen was followed in LE. After 1-year period of follow-up, the BCVA is 20/20 in LE with no activity of CNV after six intravitreal aflibercept injections (Figure 2).