**Sir,
 Regarding 'transient visual loss due to reversible
 'pending' central retinal artery occlusion in occult giant cell
 arteritis'**

I read with interest the correspondence published by Sane *et al*¹ describing the fluorescein angiographic findings of reversible retinal circulatory abnormalities associated with giant cell arteritis. It is erroneously stated that this is the first time this has been reported. In 2003, I described a similar case of occult giant cell arteritis in a gentleman who had lost vision in excess of 100 times.² I presented fluorescein angiography of an attack in progress showing the total occlusion of retinal circulation and then reperfusion.

Conflict of interest

The author declares no conflict of interest.

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**Sir,
 Chorio-retinal thickness measurements in patients
 with acromegaly**

We read with interest the article by Pekel *et al*¹ comparing choroidal, foveal, and peripapillary retinal thickness between acromegaly patients and healthy adults. The authors reported that the mean subfoveal choroidal thickness (SFCT) was higher in acromegaly patients (374.4 *vs* 308.6 μ m in the study and control groups, respectively).

It would be interesting, however, to know whether this thickening occurs to the same extent throughout the macula, or if certain regions are more severely affected. There is a potential limitation in measuring choroidal thickness at a single point subfoveally because point thickness measurements can be influenced by local changes in choroidal thickness or irregularities in the choroid–scleral border. The choroid is a complex three-dimensional structure with a highly anastomosed network of blood vessels. Significant topographic variations of choroidal and retinal thicknesses at the macula have been reported.^{2,3} Some regions of the

choroid may be more sensitive to endocrinological changes in acromegaly.

It may thus be useful to measure choroidal thickness at different regions of the macula, for example, at different distances from the fovea both vertically and horizontally, or by assessing mean choroidal thicknesses of pre-defined sectors using the Early Treatment Diabetic Retinopathy Study grid.

We are curious to know if the time of the optical coherence tomography scans were standardized, or if they occurred at different times of the day. Earlier studies have demonstrated significant diurnal variation of SFCT measured using spectral-domain optical coherence tomography.⁴ As the amplitude (difference between the maximum and minimum choroidal thickness) has been reported to be as high as 67 μ m, and this amplitude is greater among patients with thicker choroids,⁴ the observed difference in SFCT between diseased and normal eyes in this study (mean 65.8 μ m) could partly be accounted for by diurnal variation.

In summary, we congratulate the authors on their interesting findings and look forward to further studies examining the ocular effects of acromegaly at various regions of the macula. It is increasingly evident that the choroid has important roles in normal physiology and in ocular diseases, the study of which will be greatly facilitated by the new swept-source optical coherence tomography devices.⁵

Conflict of interest

The authors declare no conflict of interest.

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