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CORRESPONDENCE

Sir,

Comment on: 'Combination of peripheral laser photocoagulation with intravitreal bevacizumab in naive eyes with macular edema secondary to CRVO: prospective randomized study'

The article by Chhablani *et al*[1] has several shortcomings that prevent the validation and extrapolation of their results and that can be specifically summarized as follows:

1. Several critical data are missing from the article (Table 1).
2. The patients belonged to two different etiological groups with definitely different prognoses, namely, patients in the monotherapy group were older than 50 years, where common systemic vascular conditions should be considered; by contrast, patients in the combination group had <50 years of age and to which other mechanisms (hyperviscosity/inflammation) should be specifically accounted for.
3. Initially, a comparison had to be carried out between the two groups to establish whether or not they are comparable. Accordingly, this comparison should have been conducted only if there were no significant differences between all variables of the two groups. It sounds that patients in the monotherapy group had a less-progressed disease (eg, thinner macula and better visual acuity) than those in the combination group.
4. Evaluation of the outcomes has to be guided by anatomical measure data with visual changes as a secondary guide. Although improving vision was progressive and ascending, decreasing central subfield thickness (CST) was significant to 515.2 and 623 μm in the monotherapy and combination groups, respectively. Notably, these values are much more than the cutoff (315.2 μm) for the upper level of normal foveal thickness (270.2 ± 22.5)[2] plus 2 SDs. We believe that despite remarkable improvements in vision, the persistence of high values of the CST indicates insufficient macular deturgescence, as well as that the disease process is still active and progressive. Presumably, ischemic damages appeared during the period of time when the patients went without treatment because therapy was initiated within 9 months (mean 2.7 and 1.37 months in the monotherapy and combination groups, respectively) of central retinal vein occlusion (CRVO) onset.[3] These lesions were exacerbated during the follow-up when the treatment applied was insufficient. The standard injection scheme during the first year of intravitreal bevacizumab (IVB; Avastin, Genentech Inc., South San Francisco, CA, USA) therapy for macular

Table 1 Missing data from the article by Chhablani *et al*[1]

Variables
At presentation
Gender
Occlusion type (nonischemic/ischemic)
Anatomical types of macular edema (cystic changes within neurosensory retina/subretinal fluid)
Presence/absence of the relative afferent pupillary defects
Retinal capillary dropouts (no or small and very limited/$\geq$10 disc areas of nonperfusion)
Cotton wool spots (rare/$>$5)
Primary open angle glaucoma
Ocular hypertension
Systemic comorbidities
Arterial systemic hypertension
Diabetes
Dyslipidemia
Cardiovascular diseases
Cerebrovascular diseases
Hematology results
Clearly predefined retreatment criteria for reinjection
Manner in which informed consent was obtained and the institution that approved this study
At the end of the study (month 12)
Anatomical types of macular edema (cystic changes within neurosensory retina/subretinal fluid)
Percentage of eyes considered 'dry' on OCT as per criterion of CST $<$320 μm
Retinal capillary nonperfusion zones
Cotton wool spots
Incidence of neovascular complications

Abbreviations: CST, central subfield thickness; OCT, optical coherence tomography.

edema due to CRVO was definitely set by the level I evidence of the Swedish trials.[4]

In conclusion, we favor long-term IVB treatment and add paretinal photocoagulation only in CRVO patients with intraocular neovascularization unless this complication subsides after medical treatment.[5]

Conflict of interest

The authors declare no conflict of interest.

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We have completed and submitted the ICMJE form for disclosure of potential conflicts of interest. The authors have not a financial relationship. No organization sponsored the research. Both authors (DC and MC) were involved in design and conduct of the study; collection, management, analysis, and interpretation of the data; and preparation, review, or approval of the manuscript. We have full control of the primary data and agree to allow the *Eye* Journal to review our data if requested.

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Sir,
Combination of peripheral laser photocoagulation with intravitreal bevacizumab in naive eyes with macular edema secondary to CRVO: prospective randomized study

We thank Drs Călugăru for their interest in our publication.[1,2] Owing to the limited number of words in our manuscript we could not provide detailed data about the study patients. We did match the groups for baseline characteristics and found no significant difference. Necessary systemic investigations were performed for the patients. 1 Electroretinography was performed at 6 months and 12 months, and we did not notice any ischemic conversion. We repeated fluorescein angiography at 6 months and at 12 months follow-up to assess the ischemia. One patient required additional laser photocoagulation at 6 months in view of visible ischemia on FFA. We did not find any neovascular complication in our study patients.

We again thank the authors for their interest.

Conflict of interest

The author declares no conflict of interest.

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Sir,
Visual loss in uveitis

Quartilho *et al*[1] present the recent aetiology of visual impairment in England and Wales. A brief scan of these figures raises the immediate question—where is uveitis? These inflammations may cause severe vision impairment in up to 22% of patients in the UK,[2] disproportionately in patients of working age. The problem is worldwide: a recent study from Brazil[3] found that uveitis was the second most common cause of vision impairment (15.7%)