

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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Sir, Combination of peripheral laser photocoagulation with intravitreal bevacizumab in naïve 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 Brazil³ found that uveitis was the second most common cause of vision impairment (15.7%)

and in Singapore⁴ 7.5% had severe vision loss, most commonly from cataract and glaucoma.

The current CVI registration form contains only 'chorioretinitis (unspecified), H30.9' as a specific uveitis category. However, a recent large study from this tertiary centre⁵ permits only 671 of 3000 uveitis patients (21%) to be so labelled if severely affected. Uveitis causes visual loss from direct inflammation, but also substantially from macular oedema, epiretinal membrane, cataract, glaucoma, choroidal neovascular membrane and retinal detachment. One might suspect that in addition to the 0.43% of patients with chorioretinitis recorded by the authors,¹ many of the patients with uveitis in this study are 'hiding in plain sight' within 'secondary glaucoma', 'cataract', 'other retinal disorders' and so on. At a time when great advances in the control of uveitis by immunosuppression and biologic therapy are being thwarted by funding restrictions, it would mean a disservice to affected patients if their disease cannot be adequately represented in vision impairment statistics. For those attempting to record accurately and to raise the profile of uveitis in the registration process, the most useful codes for the few open-field boxes on the CVI form include the following:

H20.1 Chronic iridocyclitis

H26.2 Complicated cataract (includes chronic iridocyclitis)

H30.1 Disseminated chorioretinal inflammation

H31.0 Chorioretinal scars (there is no ICD10 code for macular oedema or epiretinal membrane)

H35.0 Includes retinal vasculitis

H40.4 Glaucoma secondary to eye inflammation

H44.4 Hypotony of eye

Conflict of interest

The author declares no conflict of interest.

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Sir, Uveitis certifications

We thank Mr Jones¹ for his interest in our paper reporting on the leading causes of certifiable vision impairment in England and Wales in the year ending 31 March 2013.² The cause of certifiable loss is determined by the examining consultant ophthalmologist and there is a field on the form for recording any diagnosis not presented in the picking list. It is a challenge to present this rich data source within a single report, and since this is an analysis on all ages clearly conditions that affect younger groups are likely not to feature. In answer to the question raised, we can report that there were 24 certifications with a main cause of visual loss being uveitis. We would point out, however, that this is the number of certifications rather than the numbers visually impaired—for an accurate estimate of incidence, clearly an epidemiological research study would be advised. The CVI data might, however, well serve as a useful guide for development of such valuable research.

Conflict of interest

The authors declare no conflict of interest.

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Sir, Surgery for sight: outcomes of congenital and developmental cataracts operated in Durban, South Africa

We read with interest the recent paper by Gogate *et al*¹ studying the visual outcomes of congenital and developmental cataract surgery, and determining the