and for this reason the patients are continuing to receive treatment with intravitreal aflibercept injections. This study provides a real-life clinical experience with a switch to aflibercept in eyes with resistant or recalcitrant macular oedema secondary to central retinal vein occlusion.

In addition, they mention that an average of six injections (actually our study cohort had a median of seven) of bevacizumab or ranibizumab is insufficient to label a patient as a non-responder, claiming standard protocol used in studies. However, there is no consensus on the number of injections that designate a patient as a non-responder. Bhisitkul *et al.*³ using data from the CRUISE study, classified patients as early responders (*vs* late or non-responders) based on OCT thickness <250 μm 3 months after initiation of treatment. As our study reflects real-life practices, physicians used their own discretion to designate a patient as a poor or non-responder after no less than three injections as stated in the paper and in the example in Figure 4.

They also believe that the poor anatomical and visual benefits presented in our patients can be attributed to the low frequency of injections, the period of time without therapy (a median of 1.25 months before the initiation of treatment), and the period of time when the patients were insufficiently treated with bevacizumab/ranibizumab (12 months). We do not think that the delay in treatment by a median of 1.25 months adversely affected the outcome, as patients who were enrolled in the CRUISE study⁴ had also a median of 2 months from diagnosis to screening. In our study, the mean interval of injections before the switch was 5.6 weeks and after the switch was 7.6 weeks, as the majority of the patients were on a treat and extend regimen. Indeed, the patients did not experience long-term improvement in vision after the switch to aflibercept despite improvement in macular thickness from 536 to 279 μm at the end of the follow-up. We believe that a contributing factor for the poor functional outcome may be the disease itself. According to Bhisitkul *et al.*³ there is a subset of patients who experience reduced visual outcomes compared with early responders, and we think that the patients in our study may belong to this group. Similar trends in visual outcomes have been reported in patients with wet AMD who were similarly switched to aflibercept.^{5,6}

Conflict of interest

The authors declare no conflict of interest.

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Sir, Is intraocular pressure the only important postoperative variable? The role of first day postoperative review after vitrectomy

We read with interest the article published by Alexander *et al.*¹ assessing the necessity of day-1 postoperative review of patients undergoing pars plana vitrectomy (PPV). We have certain observations to make. All patients in this study have been given prophylactic antiglaucoma medications (AGMs). These do reduce the intraocular pressure (IOP) spike postoperatively² but, conversely, they can mask the true cause of postoperative hypotony. The cause of hypotony in the cases where AGMs were stopped has not been described. Depending on that, management can vary from intensive topical steroids to re-surgery, which is a change in routine treatment.³ Thus, the empirical use of AGMs and their subsequent cessation without investigating the true cause for hypotony is questionable.

Second, the rate of intervention is unassociated with the indication of surgery in this study. It is obvious that a complex and challenging case would be expected to develop a higher rate of intraoperative and postoperative complications. A larger study sample and subgroup analysis of the indications of surgery should give more meaningful results.

Finally, the entire article seems to center on postoperative IOP management. There are complications like corneal epithelial defects, fibrin membrane, postoperative vitreous hemorrhage, silicone oil in the anterior chamber, postoperative emesis, and most importantly, infection,⁴ to name a few, which require either deviation from the routine management or additional and extensive postoperative counseling. Also, what are the medico-legal implications of omitting day 1 review in case a sight threatening complication develops? Though the authors have addressed these issues in the discussion, the

emphasis in the study *per se* seems light handed and therefore the article title, conclusion, and summary are rather controversial. It makes the reader believe that postoperative day 1 review could be omitted in most cases of vitrectomy; however, it does not take into account a lot of variables as pointed out earlier. Perhaps as far as IOP control is concerned the postoperative day 1 visit could be spared in selected cases but, it would be interesting to see a study with a larger sample size and varied surgical cases to arrive at a conclusive guideline.

Conflict of interest

The authors declare no conflict of interest.

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Sir, Intraocular pressure is not the only important postoperative variable following vitrectomy

We thank Harshey and Madhukumar¹ for their interest in our article, but they have unfortunately either misread or misunderstood the purpose of our study. Unlike several previous studies that have focused solely on intraocular pressure on the first postoperative day,^{2–4} the primary outcome measure of our study was the need for a change in treatment. We have explicitly stated this in the discussion.⁵

Of the 273 patients included in the study, 10 patients required an unexpected intervention. Of these 10 patients, 7 required a change in treatment due to intraocular pressure, while three patients needed a return to theatre for anterior chamber washout for other reasons. Therefore, our study demonstrates that intraocular pressure is not the only important postoperative variable following vitrectomy, but that it is the most common reason for a change in treatment.

Harshey and Madhukumar are concerned about the medicolegal implications of omitting the day-1 review, and one of the reasons for conducting this study was to provide contemporary data. This is particularly important given that more than a third of VR surgeons in the United Kingdom have already abandoned review on the first postoperative day.⁶

Harshey cites the paper by Schubert that discusses mechanisms of hypotony, but this reference, almost 20 years old, is now outdated and not relevant in the era of modern small-gauge vitrectomy. We would propose that the commonest cause of hypotony on day 1 after vitrectomy is wound leak from a sutureless sclerotomy incision. In our study, hypotony was observed in five patients, of whom one required reformation of the anterior chamber. The remaining four patients were treated with a change in treatment regimen and the IOP normalised in these four patients within 48 h.

To our knowledge, ours is the largest series reported in the published literature of post-vitrectomy intervention rates on day 1, but we would encourage surgeons from other centres to publish their outcomes to provide more data for this interesting and clinically relevant debate.

Conflict of interest

The authors declare no conflict of interest.

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