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References

1 Takkar B, Azad S. Comments on 'Long-term outcomes of phakic patients with diabetic macular oedema treated with intravitreal fluocinolone acetonide (FAc) implants'. *Eye (Lond)* 2016; **30**: 1023.
2 Yang Y, Bailey C, Holz FG, Eter N, Weber M, Lotery A *et al.* Long-term outcomes of phakic patients with diabetic macular oedema treated with intravitreal fluocinolone acetonide (FAc) implants. *Eye (Lond)* 2015; **29**: 1173–1180.
3 Campochiaro PA, Brown DM, Pearson A, Ciulla T, Boyer D, Holz FG *et al.* Long-term benefit of sustained-delivery fluocinolone acetonide vitreous inserts for diabetic macular edema. *Ophthalmology* 2011; **118**(4): 626–635.e2.
4 Elaraoud I, Andreatta W, Kidess A, Bhatnagar A, Tsaloumas M, Quhill F *et al.* Use of fluocinolone acetonide for patients with diabetic macular oedema: patient selection criteria and early outcomes in real world setting. *BMC Ophthalmol* 2016; **16**(1): 3.

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Sir,
Treatment trials for diabetic macular oedema

In a recent review in *Eye*, Amoaku *et al*[1] identify the need for a therapy for centre-involved diabetic macular oedema (DMO) that (i) dries the retina and improves visual acuity for a significant period, (ii) reduces adverse events, treatment burden, and costs, and (iii) is well-tolerated by patients.[1] They then make the case for an intravitreal injection regime that includes both steroids and antagonists against vascular endothelial growth factor (VEGF). The rationale was based on myriad putative mechanisms of drug action together with the results of randomised controlled trials of monotherapies. Combining a steroid with an anti-VEGF agent was said to hold promise of improved anatomical and functional outcomes together with a reduction in the (otherwise monthly) regularity of injections. This is despite the fact that previous clinical trials have shown no such adjunctive benefit.[2–5]

In the experience of many vitreoretinal surgeons, a permanent cure for DMO can often be achieved by 'one-off' vitrectomy and removal of the internal limiting membrane (ILM). A neuroprotective and sustentacular role for reparative intraretinal gliosis has been invoked. Recently, the superiority of ILM peeling over other therapies for DMO has been suggested by a non-randomised study.[6] If future trials of intravitreal therapies for DMO are contemplated, one arm of the study should comprise vitrectomy and ILM peeling.

Conflict of interest

The author declares no conflict of interest.

References

1 Amoaku WM, Saker S, Stewart EA. A review of therapies for diabetic macular oedema and rationale for combination therapy. *Eye (Lond)* 2015; **29**: 1115–1130.
2 Ahmadieh H, Ramezani A, Shoeibi N, Bijanzadeh B, Tabatabaei A, Azarmina M *et al.* Intravitreal bevacizumab with or without triamcinolone for refractory diabetic macular edema; a placebo-controlled, randomized clinical trial. *Graefes Arch Clin Exp Ophthalmol* 2008; **246**: 483–489.
3 Soheilian M, Ramezani A, Obudi A, Bijanzadeh B, Salehipour M, Yaseri M *et al.* Randomized trial of intravitreal bevacizumab alone or combined with triamcinolone versus macular photocoagulation in diabetic macular edema. *Ophthalmology* 2009; **116**: 1142–1150.
4 Marey HM, Ellakwa AF. Intravitreal bevacizumab alone or combined with triamcinolone acetonide as the primary treatment for diabetic macular edema. *Clin Ophthalmol* 2011; **5**: 1011–1016.
5 Lim JW, Lee HK, Shin MC. Comparison of intravitreal bevacizumab alone or combined with triamcinolone versus triamcinolone in diabetic macular edema: a randomized clinical trial. *Ophthalmologica* 2012; **227**: 100–106.
6 Adelman R, Parnes A, Michalewska Z, Parolini B, Boscher C, Ducournau D. Strategy for the management of diabetic macular edema: the European vitreo-retinal society macular edema study. *Biomed Res Int* 2015; **2015**: 352487.

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Sir,
Myopic traction maculopathy

I read with interest the recent article 'Myopic foveoschisis: a clinical review' by Gohil *et al*.[1]

The review is an excellent summary of all literature on this interesting topic; nevertheless, one of the largest surgical case series is missing.

This paper was published by Panozzo and Mercanti in 2007, and describes 24 highly myopic eyes with myopic traction maculopathy (MTM) successfully treated by pars plana vitrectomy with epiretinal and ILM peeling.[2] Differently from other published series, the authors achieved complete retinal settling in 23 of 24 eyes without any gas tamponade in a mean time of 4.4 months.

This series is not only one of the largest series ever published, but it is also in my opinion to be mentioned because the surgical success obtained by simple peeling without tamponade strongly supports the hypothesis that MTM is mainly due to diffuse traction from epiretinal forces and from the non-elastic ILM stretched by the myopic bulb elongation and staphyloma.

Conflict of interest

The author declares no conflict of interest.

References

1 Gohil R, Sivaprasad S, Han LT, Mathew R, Kiousis G, Yang Y. Myopic foveoschisis: a clinical review. *Eye* 2015; **29**: 593–601.
2 Panozzo G., Mercanti A. Vitrectomy for myopic traction maculopathy. *Arch Ophthalmol* 2007; **125**: 767–772.

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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

Increased vascular endothelial growth factor (VEGF) production has been reported in central retinal vein occlusion (CRVO), which could be due to peripheral retinal ischemia.[1] Panretinal laser photocoagulation (PLP) in peripheral retina has been shown to reduce the VEGF production.[2] Here, we report 1-year results of a prospective randomized single-masked trial comparing 1.25 mg intravitreal bevacizumab pro-re-nata (PRN) monotherapy and PRN therapy in combination with PLP at 1 month in treatment of naive eyes with macular edema (ME) secondary to CRVO.

Naive eyes with center-involving ME secondary to CRVO of <9 months duration, minimum central subfield thickness (CST) of 250 μm on spectral domain optical coherence tomography, and best-corrected visual acuity of 24–73 letters were included. Subjects were randomized to either monotherapy or combination group. Through month 12, subjects were evaluated monthly and treated with intravitreal injections on a PRN basis as per predefined retreatment criteria. Seven field fluorescein angiography and electroretinography (ISCEV standards) were performed at baseline, month 6 and month 12. Wilcoxon signed-rank test was performed to evaluate changes in visual acuity and CST.

Twenty-two eyes of 21 consecutive subjects were enrolled. Baseline characteristics of both groups are shown as Table 1. Mean change in visual acuity in monotherapy and combination group at the last visit from baseline was 24.61 ($P=0.001$) and 25.49 ($P=0.001$) letters, respectively ($P=0.32$). Mean decrease in CST in monotherapy and combination group at the last visit from baseline was 515 ± 202 ($P=0.0002$) and 642 ± 224 ($P=0.0003$) microns, respectively ($P=0.3$) (Figure 1). Mean number of injections in monotherapy and combination group was 6.0 ± 3.17 and 6.7 ± 3.59, respectively ($P=0.33$). There was no significant difference in b/a ratio on ERG between two groups.

Spaide[3] reported outcome of 10 eyes, which underwent peripheral laser photocoagulation during the treatment with ranibizumab. He reported no difference in the number of injections (3.4 *vs* 3.1) 6 months before and after peripheral laser photocoagulation. Similar to our results, RETAIN and RELATE trials also reported no benefits of PLP.[4,5]

In conclusion, early PLP in eyes with CRVO neither shows additional benefits on functional outcome nor to reduce the number of injections during the 1-year follow-up.

Table 1 Baseline characteristics of study groups

Characteristics	*Monotherapy group*	*Combination group*
Number of eyes	12	11
Mean age (years)	52.46 ± 14.5	45.9 ± 8.1
Mean duration of symptoms (months)	2.7 ± 3.4	1.37 ± 1.3
BCVA in ETDRS letters	39.2 ± 17.05	32.9 ± 14.99
Mean intraocular pressure (mmHg)	13.9 ± 3.5	13.9 ± 2.8
Mean baseline CST (microns)	829 ± 332	870 ± 295
Photopic 3.0 ERG (b/a ratio)	2.6	2.47
Photopic 3.0 flicker (b/a ratio)	2.58	2.4
Scotopic 3.0 ERG (b/a ratio)	2.53	2.42

Abbreviations: BCVA, best-corrected visual acuity; CST, central subfield thickness; ETDRS, Early Treatment Diabetic Retinopathy Study.