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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.

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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.

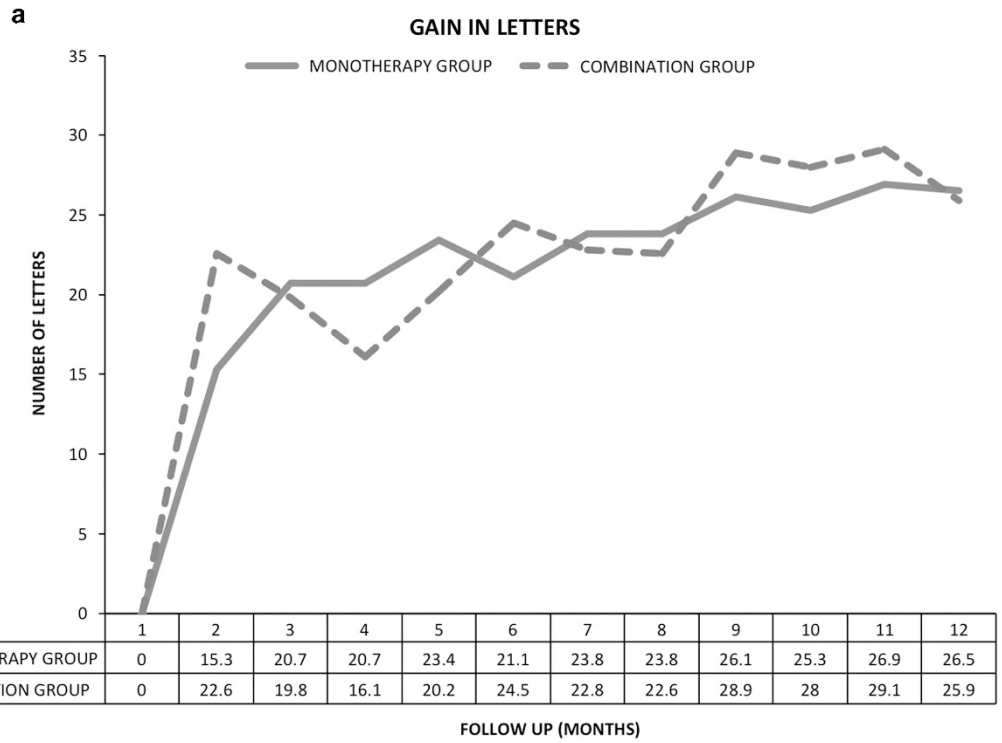
Spaide[3] reported outcome of 10 eyes, which underwent peripheral laser photocoagulation during the treatment with ranibizumab. He reported no difference in the number of injections (3.4 *vs* 3.1) 6 months before and after peripheral laser photocoagulation. Similar to our results, RETAIN and RELATE trials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

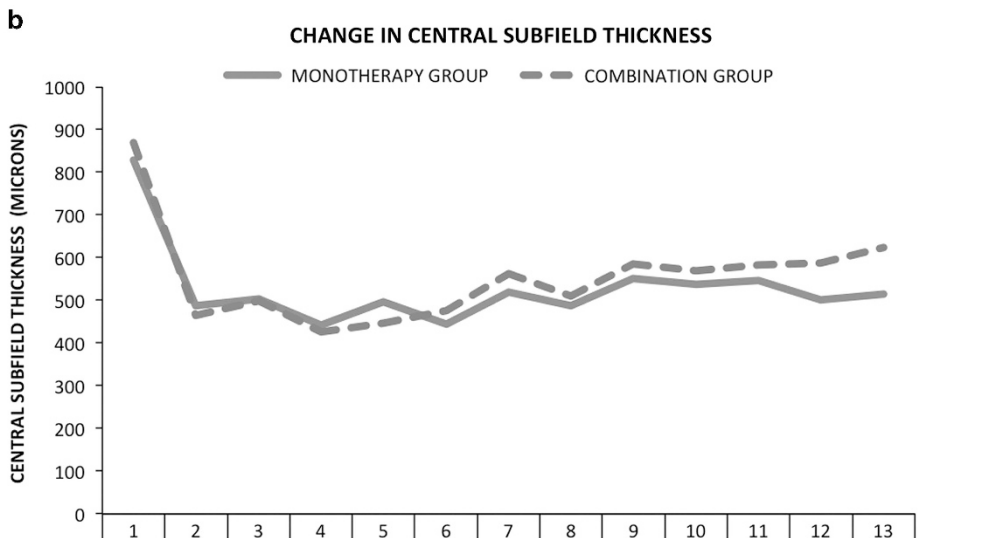
Characteristics	*Monotherapy group*	*Combination group*
Number of eyes	12	11
Mean age (years)	52.46 ± 14.5	45.9 ± 8.1
Mean duration of symptoms (months)	2.7 ± 3.4	1.37 ± 1.3
BCVA in ETDRS letters	39.2 ± 17.05	32.9 ± 14.99
Mean intraocular pressure (mmHg)	13.9 ± 3.5	13.9 ± 2.8
Mean baseline CST (microns)	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.



	1	2	3	4	5	6	7	8	9	10	11	12
MONOTHERAPY GROUP	0	15.3	20.7	20.7	23.4	21.1	23.8	23.8	26.1	25.3	26.9	26.5
COMBINATION GROUP	0	22.6	19.8	16.1	20.2	24.5	22.8	22.6	28.9	28	29.1	25.9

FOLLOW UP (MONTHS)



	1	2	3	4	5	6	7	8	9	10	11	12	13
MONOTHERAPY GROUP	828.5	487.10	503	441.1	495.7	443.2	518.6	488	550.2	536.6	545.6	500.6	515.2
COMBINATION GROUP	870	464.8	499.7	425.3	445.8	475.7	561.8	510.4	584.6	569.3	583.3	587.6	623

FOLLOW UP (MONTHS)

Figure 1 (a) Mean change from baseline best-corrected visual acuity in Early Treatment Diabetic Retinopathy Study (ETDRS) letters over time to month 12. The last-observation-carried-forward method was used to impute missing values. Improvement in visual acuity during the treatment period was maintained in both groups till month 12 with no significant difference between the two groups ($P = 0.32$). (b) Mean change from baseline CST in microns over time to month 12. The last-observation-carried-forward method was used to impute missing values. Decrease in CST during the treatment period was maintained in both groups till month 12 with no significant difference between the two groups ($P = 0.3$).

Conflict of interest

The authors declare no conflict of interest.

Study group investigators

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J Chhablani, R Narayanan, A Mathai and M Tyagi on behalf of CRVO-Laser study group[1]

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Sir,
The Edinburgh diagnostic algorithms: a freely available validated resource for non-ophthalmologists

We would like to draw the author's attention to the recent articles published in *Eye*, which describe the diagnostic accuracy of A&E doctors and other non-ophthalmologists when faced with patients who present with three of the most common ophthalmic presentations: red eye,[1] visual loss[2] and diplopia.[3] These articles go on to describe and validate diagnostic algorithms for each presenting symptom that significantly improve the diagnostic accuracy of these non-specialists.

We found a baseline diagnostic accuracy of 51% for patients with visual loss (optometrists 67%, A&E doctors 33%, GPs 13%, and other hospital doctors and nurse practitioners 0%) and a rate of 24% in patients with diplopia (A&E doctors 38%, GPs 28%, and optometrists 13%). There was no baseline diagnostic accuracy quoted in the 'Red Eye' paper, which is one of the paper's weaknesses, however, a study from 1996 was quoted, describing a diagnostic accuracy in patients with acute angle closure glaucoma 21% from GPs and 64% from casualty officer.[4] The overall diagnostic accuracy of The Red Eye Algorithm is 72%, which rose to 76% when only the most serious causes (acute angle-closure glaucoma, iritis, and keratitis) were analysed. Diagnostic accuracy using The Visual Loss Algorithm improved from 51 to 84% and while using The Diplopia Algorithm from 24 to 82%.

Ah-kee *et al* recommend organisational changes to improve ophthalmic training and supervision to non-ophthalmic doctors nationally, which would require considerable investment of manpower and funding.[5] Although desirable, in a National Health Service where limited resources are spread thinly across every specialty these recommendations may be unrealistic. The Edinburgh Diagnostic Algorithms offer a freely accessible, immediately available, validated solution to this problem that will improve referral from primary care to ophthalmology and ultimately improve patient care.

The Edinburgh Diagnostic Algorithms are freely available online at https://www.eemec.med.ed.ac.uk/pages/resources/mw-ophthalmology-page.

Conflict of interest

MW has received minimal royalties from the sales of 'Ophthalmology Pocket Tutor' where the algorithm has been published. The remaining authors declare no conflict of interest.

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