Dear Editor,

We read with interest the article by Horozuglu et al.1 We make the following observations.

1. The authors state that 'duration of macular detachment' was recorded. It is possible to elicit the duration only by history-taking, as the subjective method is likely to be inaccurate. The authors have not mentioned the details of this finding in the article. If the duration of macular detachment was recorded, a correlation with the location of break, and post-operative visual gain should have been expressed.

Primary 25-gauge transconjunctival sutureless vitrectomy in pseudophakic retinal detachment

1. Mohammad R Khalili, Hamid Hosseini. Debate on the various indications and contraindications of each will require large, prospective, planned studies. With the availability of selective as well as pan-VEGF blockade agents, the roles, retinopathies than it is in AMD. However, with the availability of selective anti-VEGF agents in the context of ischaemic retinal diseases.

Vascular endothelial growth factor: A is a survival factor for retinal neuron survival, in a model of ischemia-reperfusion injury. Ischemic preconditioning 24 h before neuroprotectant in neural cell survival, in a model of ischemia (Avastin). Indian J Ophthalmol 2007;55:437-9.

Another study5 characterized VEGF localization in diabetic retinopathy using staining pa...
2. The authors state that after pars plana vitrectomy (PPV), perfluorocarbon liquid (PFCL) was injected and immediately PFCL-air exchange was done, and endolaser was applied under air. This means that retina could flatten under air only. Why was then PFCL injected initially? Fluid-air exchange with endo drainage would have been enough. Use of PFCL was superfluous and if this was done, endolaser could have been applied under PFCL as it gives better visualization than air, closer approximation of neurosensory retina and retina pigment epithelium, making it possible to use low laser power.

3. Authors have mentioned the number of retinal breaks, and the size of retinal detachment in Table 1 of their article, but not the location. Only gas tamponade has been used and inferior breaks are not likely to close with gas tamponade and posture alone. Were all the breaks superior in location?

4. The authors mention the use of sodium hyaluronate 1% to fill up anterior chamber to prevent passage of air in anterior chamber. Air can come to anterior chamber only if posterior capsule has a break and in such a situation, viscoelastic also cannot prevent it. Viscoelastic is injected in anterior chamber and will lie on the surface of IOL and the surrounding intact posterior capsule. Opening in posterior capsule is generally under IOL and will not be blocked by viscoelastic. Air enters the eye under pressure and will always move up, while viscoelastic will settle down with gravity. It is difficult to accept that viscoelastic will prevent the entry of air in anterior chamber, except when there is tight fill of viscoelastic in anterior chamber creating high positive pressure to keep the air pushed back. This will mean injection of a large amount of viscoelastic in anterior chamber. The authors have not mentioned the amount injected by them. The authors state that a prone posture was maintained for five days. This as such will keep the gas/air back, leaving viscoelastic in the anterior chamber; this appears unnecessary and can give rise to complications.

5. The authors state ‘increased patient comfort’ is an advantage of this procedure, while they mention to keep prone posture for five days. In case of superior breaks and PPV with sutures, prone posture is not needed; rather an erect or a chin-down posture is needed, and there is no risk of gas leak as the sclerotomies are closed. Have they maintained a prone posture to prevent leakage of gas as the sclerotomies were not sutured? It is contrary to their claim of patient comfort or they have done so to take care of inferior breaks? In that case, they have not given any details of location of breaks, which to our mind is the most important information about a case of retinal detachment? In any case, inferior breaks will require a buckle.

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References
1. Horozoglu F, Yanyali A, Celik E, Aytug B, Nohutcu AF. Primary 25-gauge transconjunctival sutureless vitrectomy in pseudophakic retinal detachment. Indian J Ophthalmol 2007;55:337-40.