**Decompression retinopathy after intravitreal bevacizumab and anterior chamber paracentesis in a patient with neovascular glaucoma**

Sir,

Decompression retinopathy is defined as retinal hemorrhages that typically occur after glaucoma filtration surgery. We recently experienced an unusual case of decompression retinopathy following intravitreal bevacizumab injection and anterior chamber paracentesis in a patient with neovascular glaucoma (NVG), thus herein report the case.

A 56-year-old female with type II diabetes, who had been previously diagnosed with bilateral proliferative diabetic retinopathy accompanied with NVG, presented with visual disturbance in his left eye. The best-corrected visual acuity (BCVA) was 20/25 in the right eye and 20/400 in the left eye. The intraocular pressure (IOP) was 11 mmHg in the right eye and 47 mmHg in the left eye despite treatment with both topical dorzolamide/timolol fixed combination and brimonidine twice a day. The left pupil was fixed (4 mm) and non-reactive to light. Slit-lamp examination showed active iris neovascularization and mild nuclear sclerosis in the left eye [Fig. 1]. Fundus examination of the left eye showed a hazy view due to corneal edema [Fig. 2]. We immediately injected intravitreal bevacizumab (1.25 mg/0.05 ml) and performed an anterior chamber decompression retinopathy after intravitreal bevacizumab and anterior chamber paracentesis in a patient with neovascular glaucoma.
In conclusion, this case demonstrates that decompression retinopathy can occur following intravitreal bevacizumab and anterior paracentesis. Precautions should be taken to reduce the risk of this complication. A sudden drop of the IOP should be avoided by a careful anterior paracentesis, releasing the aqueous very slowly, to prevent shallow anterior chamber during the paracentesis. It may also be beneficial to perform paracentesis in several smaller stages to reduce the risk of adverse responses to a sudden decrease in IOP.

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Nil.

**Conflicts of interest**
There are no conflicts of interest.

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Sir,

We read with interest the article written by Shuang and Yichun (2016) entitled, "A Case of Perforating Injury of Eyeball and Traumatic Cataract by Acupuncture". The article does trigger an alarm in the standardization of clinical acupuncture, but we are still confused about the case.

Aiming to avoid similar accidents in the clinical practice, we decide to seriously analyze this case. Since the authors are ophthalmologists instead of acupuncturists, they do not give a detailed account of the acupuncture therapy in this article. Judging from the text and pictures, it is discovered that the perforated cornea and iris are the major cause of traumatic cataract and subsequently patient's vision loss.

However, there are several uncertainties about the case: First, we are curious about the selection of acupoints and its selecting principle, as well as the acupuncture manipulations adopted for cerebral infarction; second, as shown in the picture, what we find is only two holes with a diameter of 3 mm, which does not conform to the use of acupuncture needles with a diameter of 0.25 mm in clinical practice; furthermore, based on the position of the holes, it is puzzling that how we could reach the spot in acupuncture therapy. Why did the performer take no notice of the acupuncture dangers or patient's pain or bleeding at that time? If the performer did apply eye acupuncture therapy, the extraocular horizontal insertion, instead of needling into eyes, would be recommended. Due to the risk in needling acupoints around eyes, we are especially careful, and few people would choose them to treat cerebral infarction. We would like to clarify why the performer chooses that therapy.

Due to this article's essence on the accident of acupuncture, we come to believe that a large number of acupuncturists would be interested in the article. Therefore, it is suggested that the authors should give more detailed description of the patient's history of present illness, which would objectively influence the acupuncture.

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