Response to comment on: Efficacy of low-concentration atropine (0.01%) eye drops for prevention of axial myopic progression in premyopes

Dear Editor,

We thank Patil et al. for showing interest in our study.\(^1\) It is indeed a topic that has paramount importance as this is the right area where intervention may lead to important future implications. The problem is that it is difficult to have children who fit into these specific criteria, to do axial length in this age group, and to keep track of children who are emmetropic and yet may have a chance of developing myopia.\(^1,2,3\)

A group of children may eventually not even progress; therefore, only children whose spherical equivalent (SE) was less than +1.0 D, who were close to emmetropia, and had a history of progression were taken up for this study. At the end of the study period, that is, 2 years, 63.3\% (n = 19) of children in the low-concentration-atropine (LCA) group and 96.7\% (n = 29) in the control group needed spectacles.

All children who were willing (meaning consent was given) and were cooperative underwent corneal topography. Children who were not cooperative for the investigations or were lost to follow-up were excluded from the study.\(^2\)

The patients included did not have a family history of pathological or high myopia mainly to reduce the bias of children who would end up having high myopia and would not be responsive to LCA eye drops as that would also have induced a bias on either group.\(^2,4\)

LCA drops were chosen not only for their less effect on rebound but also for the fact that there are minimal effects on accommodation and on systemic problems with which atropine 1\% eye drops is associated quite frequently. Also, the fact that the study would be continued was not mentioned, and we thank Patil and Murthy\(^1\) for giving us a chance to mention that we would be further publishing the results of rebound as well as other factors that affected the progression of myopia and the quantum of myopia along with axial length. At this point of time, we started LCA drops in 93.3\% (n = 28) of children in the control group.

Both the groups were age-matched and school-going. Although we tried to account for the history, this could be different and randomly distributed among the children. We admit that we did not have any control over these parameters.

The study had a small sample size, and subgroups were still smaller to have a meaningful conclusion. Online classes were there for all the groups, and online activities were not restricted to just the classes but even otherwise also as the outdoor activities were completely at halt during COVID-19 lockdowns. In the study group, 17 children (56.7\%) were in the age group of 9–12 years, whereas in the control group, there were 19 (63.3\%) children. At the end of the second year, the mean progression compared with the baseline in the LCA group was −0.8 ±0.4 D versus −1.6 ±0.4 D in the study group and control group, respectively.

The purpose of the study was mainly to address the issues of prematurity in the Indian population along with the efficacy of LCA drops in children with prematurity. There will always be a subset of children who would not have progressed or whose progression would have stopped between the study owing to age or otherwise, and it is very difficult to know as myopia is multifactorial.

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

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