resolved by month 12. Furthermore, all eyes had cataract surgery either before (n = 6) or in conjunction (n = 2) with combined dexamethasone intravitreal implant and glaucoma drainage device placement. Thus, cataract was not a cause of visual acuity changes in the postoperative period.

With regards to the status of the angle, preoperative gonioscopy demonstrated either open angles without synechiae (n = 6) or few scattered peripheral anterior synechiae (n = 2). Systematic measurement of anterior chamber depth and postoperative gonioscopy were not performed. In addition, all eyes (n = 8) had no previous glaucoma filtering surgeries and had the glaucoma drainage device placed in the anterior chamber.

As noted by Bansal and colleagues, future prospective studies comparing the effectiveness of combined dexamethasone intravitreal implant with glaucoma drainage device versus glaucoma drainage device alone will help further elucidate the risks and benefits of this surgical approach for managing uveitic glaucoma.

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Effects of Intravitreal Anti-VEGF Therapy on Glaucoma-like Progression in Susceptible Eyes

**To the Editor:**

We read with great interest the recently published article “Effects of intravitreal anti-vascular endothelial growth factor (VEGF) therapy on glaucoma-like progression in susceptible eyes” by Du and colleagues and would like to appreciate the work of the authors for the same. It highlights well the need for a reliable preinjection visual field analysis/optical coherence tomography (OCT) and the need for constant intraocular pressure monitoring and regular glaucoma follow-up in patients with coexisting glaucoma and retinal disease.

We would like to highlight a few points in the study that require some clarification.

First, in the inclusion criteria, it is mentioned that a minimum of 2 consecutive Humphrey visual field or retinal nerve fibre layer (RNFL) thickness by OCT have been considered for chart analysis (minimum duration between baseline and second test being > 12 mo). However, it is not very clear how they have assessed progression and what were the number of fields studied for glaucoma progression analysis. It would be of value to mention the average number of fields/OCT per patient studied in both the groups (injected and noninjected eyes) because 2 to 3 fields/OCT might not be enough to accurately study progression in such eyes. Moreover, patients of retinal diseases can have fallacious results of perimetry/RNFL due to progression of retinal disease itself. Monitoring of fundus photographs to look for disc changes might be a better option in such cases.

Second, retinal lasers have not been excluded from the study. An article published in October 2019 by Wadhwani et al. concludes that PRP can cause RNFL thinning on long-term follow-up. Hence, it is not clear whether any of the patients underwent retinal laser treatment because that can confound the perimetry and OCT findings.

Another point to be looked into is the study of the noninjected eyes as the control group to study the natural progression of pre-existing glaucoma in these patients. Although, at baseline, both the groups were almost similar in severity of glaucoma in terms of baseline intraocular pressure, number of pre-existing glaucoma drops, number of prior invasive glaucoma interventions, mean deviation and pattern standard deviation on visual field analysis, and RNFL thickness on OCT, it is well known that bilateral eyes of primary open angle glaucoma can show asymmetrical progression and hence, just by comparing with the noninjected fellow eye, we cannot truly comment whether the progression in injected eyes could be attributed to pre-existing glaucoma or due to the anti-VEGF injections.

Last, there is no mention about the number of injections in the eyes that progressed and required further glaucoma surgery or laser. It would be worthwhile to study any co-relation between the number of anti-VEGF injections and progression.

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Response to: Effects of Intravitreal Anti-VEGF Therapy on Glaucoma-like Progression in Susceptible Eyes

In Reply:

We thank Dr Kumari and Dr Dubey for their thoughtful review of our study, and for highlighting some important points that we will address.

In assessing glaucomatous progression, the baseline visual field or optical coherence tomography test and next test closest to 12 months after starting anti-VEGF therapy were selected to calculate rate of change in functional and structural parameters. Although subjects underwent perimetry and optical coherence tomography examinations multiple times over the study period, the decision to use just 2 fields or examinations allowed for standardized rates of change that corresponded to the initiation of injections. However, given that patient performance on perimetry fluctuates, we acknowledge that this lowers the reliability and may be weakness of our analysis. Likewise, we recognize that retinal disease could contribute to retinal nerve fiber layer changes, such as with resolution of edema. Patients with a history of laser photoagulation were not included in the study.

With regards to the point on asymmetric progression of glaucoma, indeed this may affect comparisons between injected and fellow eyes, even though measurements of baseline characteristics were similar when averaged between groups. However, visual field progression correlates between eyes in patients with chronic open-angle glaucoma and patient-specific factors such as systemic comorbidities and environment are also well controlled for when using the fellow eye to evaluate natural progression. In future studies, the inclusion criteria could be refined to ensure similar baseline severity of glaucoma in both eyes for each individual subject, excluding those with significant asymmetry.

Finally, we agree that examining the correlation between number of injections and functional/structural change would be worthwhile and may strengthen the argument that progression was related to injections rather than to preexisting glaucoma. Longitudinal monitoring of disc changes and other clinical measures that are more specific to glaucomatous disease may also help to distinguish the effects of glaucoma from retinal disease and other confounding factors. We appreciate the helpful suggestions by Dr Kumari and Dr Dubey.

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The Impact of Routinely Measuring IOP in Younger Adults to Screen for Glaucoma in a Large Eye Hospital

To the Editor:

We would like to congratulate Garzon et al for the study “The impact of routinely measuring IOP in younger adults to screen for glaucoma in a large eye hospital” which opens up a new paradigm in the management of glaucoma in developing countries where intraocular pressure (IOP) measurement is routinely done only for patients more than 40 years of age. However, we would like to emphasize a few points which require further discussion.

Prevalence of glaucoma in India as reported by several population-based studies varied between 1.6% and 4% among people more than 40 years of age. Marx-Gross et al had reported the prevalence of glaucoma in people between 18 and 40 years of age to be 0.16% in their population. Even though the prevalence was very low below 40 years of age the benefit of diagnosing and treating them early will have a huge impact on the life of the person, family, and society as they have a long life span.

The cost to diagnose 1 patient was mentioned as Indian rupee 596 in the study and the author had concluded that the benefit of diagnosing glaucoma outweighs the cost involved considering the burden of the disease. The cost spent diagnosing was mainly attributed to the labor cost as the hospital owns the other instruments needed for the diagnosis of glaucoma. The study was a retrospective study conducted in a hospital setting, hence there was no need for extra labor as we require in population-based studies. Patients included in the study were walk-in patients who came for a check-up and most of them if not all would have paid for the check-up. The cost for a check-up will be the same irrespective of the age of the patient coming to the hospital, if IOP can be checked for patients more than 40 years of age the same can be done for patients below 40 years without any extra labor cost. Last, all health care workers have a fixed pay role. Considering all this we would rather say the cost to diagnose a patient below 40 years of age with glaucoma in a hospital setting was very negligible, which justifies without a second thought about the cost involved to use IOP measurement as a screening tool to diagnose glaucoma in its early stage in young people.

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