Dear Editor,

We read with interest the article on sub-macular hemorrhage by Rishi et al.\(^1\) We congratulate the authors for bringing out this article as there is paucity of information especially, with regard to the management and prognosis. Authors have pointed out the histological location of the sub-macular hemorrhage on optical coherence tomography (OCT) being sub-retinal and sub-RPE pigment epithelium (RPE). They have also rightly inferred that sub-RPE bleed is not amenable to pneumatic displacement. However, we beg to differ on their comment that sub-RPE hemorrhage have poor prognosis irrespective of the etiology.

We would like to share our experience of managing traumatic submacular hemorrhage based on SD-OCT. In our initial published case report,\(^2\) we have demonstrated that it is important to differentiate the histological location of the bleed into sub-photoreceptor and sub-RPE bleed. In patients with purely sub-RPE bleed, pneumatic displacement probably has no role and the patient have a good chance of visual recovery without any treatment to displace the blood, provided the choroidal rupture does not involve the foveal center.

Two of our patients presented with traumatic sub-macular hemorrhage. The first case had sub-RPE and 2nd patient had sub-photoreceptor bleed on SD-OCT. Pneumatic displacement was carried out only in the 2nd case. Even though, we did not initiate any measures to displace the sub-macular bleed in the first case, visual recovery started as early as 3 days after injury and continued to improve, which correlated with a decrease in the thickness of the sub-RPE bleed. The first case had a higher foveal elevation on raster scan (353 µ) compared with the 2nd case (104 µ), and therefore, should have had a poorer prognosis without therapeutic measures to displace the blood. Similar case of spontaneous resolution of large traumatic sub-macular hemorrhage has been reported by Chaudhry et al.\(^3\) At 6 months post-trauma both our patients recovered to a BCVA of 6/6 and have maintained the same for 2 years. So far, we have treated eight patients (sub-photoreceptor \([n = 4]\) and sub-RPE \([n = 4]\) bleed) using the same analogy and all patients with sub-RPE bleed have recovered ≥6/9 vision (minimum follow-up of 5 months) with conservative management (Unpublished data, presented at state conference, 2012).

Patients with sub-RPE bleed in other etiologies (Age Related Macular Degeneration [AMD], Polypoidal Choroidal Vasculopathy [PCV]) may have poorer prognosis due to the pathology in question rather than due to the bleed as is evident from our experience in managing post-traumatic sub-RPE bleed.

We also feel that it would be better to classify sub-macular bleed into sub-photoreceptor and sub-RPE bleed than as sub-retinal and sub-RPE so that there is clarity of nomenclature based on histology and to avoid confusion as RPE is one of the layers of the retina.

We would recommend the use of SD – OCT in all patients with traumatic sub-macular hemorrhage and one should consider pneumatic displacement only in patients with sub-photoreceptor bleed and patients with sub-RPE bleed can be observed.

We would also like to know from the authors whether all the patients treated had purely sub-photoreceptor bleed as majority of patients (31/46) in this study had a choroidal pathology (AMD/PCV) and whether OCT was used to decide management plan?

Raju Sampangi, Hemalatha B C

Department of Vitreo-Retina, Netraspandana Eye Hospital, 160, Nagarbhavi 2nd Stage, Bangalore, India

Correspondence to: Dr. Raju Sampangi, Department of Vitreo-Retina, Netraspandana Eye Hospital, 160, Nagarbhavi 2nd Stage, Bangalore, India. E-mail: rajasampangi@hotmail.com

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