2 Knox DL, Schachat AP, Mustonen E. Primary, secondary and coincidental ocular complications of Crohn's disease. *Ophthalmology* 1984; **91**: 163–173.
3 Salmon JF, Wright JP, Murray ADN. Ocular inflammation in Crohn's disease. *Ophtalmology* 1991; **98**: 480–484.
4 Dutt S, Cartwright MJ, Nelson CC. Acute dacryoadenitis and Crohn's disease: findings and management. *Ophthal Plast Reconstr Surg* 1992; **8**: 295–299.
5 Hwang IP, Jordan DR, Acharya V. Lacrimal gland inflammation as the presenting sign of Crohn's disease. *Can J Ophthalmol* 2001; **36**: 212–213.

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Sir,

The surgical management of chronic hypotony due to uveitis

Prolonged hypotony in uveitis patients is often regarded as the end stage of a chronic disease from which recovery is improbable if not impossible. However, not all hypotony cases are alike. Hypotony resulting from active inflammation will respond to adequate immunosuppression, and as indicated in our article an attempt should be made to treat it medically before considering a surgical approach. The question then is how long should one wait to observe a response.

As indicated by Dr Liu and co-workers, periocular steroids can have a prolonged effect. In certain forms of uveitis, a single periocular injection can provide a beneficial effect for 8–12 weeks. However, one would expect to see a response to steroids within the first 10–14 days. To take into account a possible delay in this initial response, we followed patients for 2 months prior to surgery. The patients included in this series did not show a pressure rise on intensified immunosuppression.

There is no doubt that steroids and other immunosuppressants contribute to the surgical result. However, the effect will not be sustained once a taper is initiated. Management in this series of patients became easier following surgery with fewer and less immunosuppressants being required. Hypotony in chronic uveitis patients is often characterized by a protracted course requiring frequent reinjections, or modifications to the immunosuppressive regimen.

For all the reasons mentioned above, and our results, we feel that a surgical approach should be considered in this group of patients. With time, we should be able to determine the place and timing of surgery in the management of this severe complication of uveitis.

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Sir,

The surgical management of chronic hypotony due to uveitis

Dr de Smet and associates have conducted an interesting study on surgical interventions for cases of uveitis-induced chronic hypotony. After a joyous reading of the whole article, we think that an important issue should warrant further discussion.

Subtenon's capsule triamcinolone acetonide injection was shown to be effective in the management of intraocular inflammation.[1,2] It has an overt advantage over systemic steroid for effaced systemic adverse effect and slow-releasing depot.[1] The biological action of subtenon triamcinolone acetonide is long and can be up to 6 weeks or even longer.[1,2]

From the methodology, it can be learned that some of the patients with intraocular inflammation were given one to two subtenon's injection prior to the surgical intervention.[3] Interestingly, if one inspected Table 1 of the article, it was noted that duration of hypotony in patient numbers 1–4 ranged from 8 to 12 weeks.[3] Apparently,

there was no washing-out period for the subtenon steroid administered. Hence, out of the six patients enrolled, four of them (66.7%) might undergo the antihypotony surgeries superimposing with the ongoing anti-inflammatory effect of the subtenon steroid depot. This is a significant confounding factor. These inadvertently overlapped medical and surgical managements may blur the attribution that the observed postoperative improvement was solely due to surgical manipulation. If uncontrolled, it may imperil the reproducibility of the proclaimed intraocular pressure-stabilizing effect of the surgery. We would like to learn more from the authors about their precautions against this important confounding influence.

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References

1 Paganelli F, Cardillo JA, Melo Jr LA, Oliveire AG, Skaf M, Costa RA, Brazilian Ocular Pharmacology and Pharmaceutical Technology Research Group. A single intraoperative sub-Tenon's capsule triamcinolone acetonide injection for the treatment of post-cataract surgery inflammation. *Ophthalmology* 2004; **111**: 2102–2108.
2 Lafranco Dafflon M, Tran VT, Guex-Crosier Y, Herbort CP. Posterior sub-Tenon's steroid injections for the treatment of posterior ocular inflammation: indications, efficacy and side effects. *Graefes Arch Clin Exp Ophthalmol* 1999; **237**: 289–295.
3 De Smet MD, Gunning F, Feenstra R. The surgical management of chronic hypotony due to uveitis. *Eye* 2005; **19**: 60–64.

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Sir,

An evaluation of photographic screening for neovascular age-related macular degeneration

We read with great interest the work of DAL Maberley *et al*[1] on the 'Evaluation of photographic screening for neovascular age-related macular degeneration'. The authors were looking at the utility of colour fundus photographs for identifying subjects with potentially treatable neovascular AMD. While the methods, analysis and conclusions of the study seem both convincing and sound, the following is a suggestion, although meager, we feel could be of value to the authors.

DAL Maberley *et al* used Kodak-chrome colour slides for both stereoscopic and nonstereo images. Although important in both documentation and diagnosis, the 35 mm colour fundus photos are slowly loosing their allure in retinal imaging. Colour slides are being replaced by the technologically more advanced digital fundus photography. This imaging tool used to give a less detailed picture in the past when compared to 35 mm, however, with the recently available 6.0 megapixel cameras, resolution of the photos has been comparable if not superior to traditional cameras. Even reference reading centres, such as the University of Wisconsin Reading Centre is gradually switching to high-resolution digital photography, replacing the gold standard 35 mm slides. Advantages in digital photography comprise better manipulation of the fundus image, including magnification and colour filtering, and easier electronic storage/e-mailing. Finally, despite an initial higher cost, the digital camera's on going financial burden is by far less than film. We suggest to our authors embarking on digital photography (stereo and nonstereo) for projects to detect retinal pathology. This was proven both valuable and effective in ample studies.[2–4] Also, by using the different image manipulation tools, the authors then might achieve an even higher sensitivity and specificity than the one reported.

References

1 Maberley DAL, Isbister C, Mackenzie P, Aralar A. An evaluation of photographic screening for neovascular age-related macular degeneration. *Eye* 2005; **19**: 611–616.
2 van Leeuwen R, Chakravarthy U, Vingerling JR, Brussee C, Hooghart AJ, Mulder PG *et al*. Grading of age-related maculopathy for epidemiological studies: is digital imaging as good as 35-mm film? *Ophthalmology* 2003; **110**: 1540–1544.
3 Merrin L M, Guentri K, Recchia CC. Digital detection of diabetic retinopathy. *J Ophthalm Photography* 2004; **26**: 59–66.
4 Bursell SE, Cavallerano JD, Cavallerano AA, Clermont AC, Birkmire-Peters D, Aiello LP, Aiello LM, Joslin Vision Network Research Team. Stereo nonmydriatic digital-video color retinal imaging compared with Early Treatment Diabetic Retinopathy Study seven standard field 35-mm stereo color photos for determining level of diabetic retinopathy. *Ophthalmology* 2001; **108**: 572–585.