

Indian Journal of Ophthalmology

HIGHLIGHTS

Anti-vascular endothelial growth factor in age-related macular degeneration:
Puzzle or a silent beginning!

Conservative treatment modalities in retinoblastoma

Demographic and clinical profile of vernal keratoconjunctivitis at a tertiary eye care center in India

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the reader for their excellent observation; however, we would like to clarify that we had used only 1000 centistokes of silicone oil in all the cases. We have addressed this issue in our review article on silicone oil removal.^[2]

It is an excellent suggestion to compare the average duration of oil removal in emulsified and no emulsified group and we would be happy to look at that aspect in a future study.

Manish P Nagpal, Rituraj P Videkar, Kamal M Nagpal

Retina Foundation and Asopalav eye Hospital, Shahibaug, Ahemedabad, India

Address for correspondence: Dr Manish Nagpal, Retina Foundation and Asopalav Eye Hospital, Near Shahibaug Underbridge, Shahibaug, Ahmedabad, Gujarat, India.

E-mail: drmanishnagpal@yahoo.com

Factors having implications on re-retinal detachments after silicone oil removal

Dear Editor.

We thank the readers for their interest and valuable comments in response to our article. We agree with the reader that two-port approach for silicone oil removal is less invasive, but hardly gives any control to the surgeon over evaluating the retinal status during the procedure. Sometimes a retinal detachment is encountered intraoperatively after silicone oil removal due to a pre-existing hidden break or reopening of the pre-existing break,[1] which until then was/were tamponade by silicone oil. We follow the three-port approach so as to tackle such an eventuality in addition to the obvious indication of laser augmentation or epiretinal membrane removal as suggested by the reader. The small gauge vitrectomy systems further reduce the chances of conjunctival scarring and can hardly be called invasive and we strongly recommend use of a three-port vitrectomy for oil removal instead of a two-port, which gives the surgeon very little on table control over checking the retinal status and can take corrective measure if required.

This study which was aimed at studying the relation between retinal re-detachment following silicone oil removal and its relation with the encirclage, laser retinopexy, duration of tamponade, emulsification of silicone oil and hence the reasons of retinal detachment such as opening of retinal break due to proliferative vitreoretinopathy (PVR) and instrument touch was out of the scope of the study. PVR is anyways present in most cases where silicon oil is injected and is an important factor anyways for any sort of recurrence of re-detachment whatsoever. We do agree that for studying the reasons of retinal detachment due to various variables a broader randomised trial would be required.

We agree with the reader that difference in densities of silicone oil can affect the results and would like to congratulate

References

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