

Vitrectomy as anti-inflammatory treatment in intermediate uveitis[☆]

De la vitrectomía como terapia antiinflamatoria en la uveítis intermedia

Dear Sir:

With reference to the article titled "Vitrectomy as an anti-inflammatory therapy for intermediate uveitis in children" by Figueroa et al.,¹ I would like to emphasize that the article does not allow the reader to deduct that vitrectomy is useful for this pathology or that it is safe because patients exhibit a high recurrence rate (albeit mostly in the anterior location) as well as a considerable incidence of post-surgery cataracts in patients with previous operations. Of the 2 cases without recurrences, one is a sarcoidosis case and the other exhibited inflammatory activity in the opposite eye and had also been intervened. It would be revealing to determine why the parents of an intervened patient opted for systemic immunosuppression instead of the surgery for the affected opposite eye. In my experience, vitrectomy in intermediate uveitis does not reduce the need of topical or periocular corticoids therapy, which must remain as therapeutic pillars together with cryotherapy or peripheral retinal photocoagulation (and not on pars plana, as referred by the article). On the other hand, I find it hard to understand how vitrectomy 20-G can be promoted in an inflammatory pathology even when the patients are children. I believe that, if asked, the vast majority of ophthalmologists would indicate a small gauge

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(which is the recommendation set forth by the authors in the discussion), even without the application of scleral sutures as these children, due to their age, have a similar ocular anatomy to that of adults. And of course, if vitrectomy is performed with this pathology, I believe peripheral retinal photocoagulation should be added in the ischemic areas posteriorly to the snow patches, together with periocular corticoids therapy in the same intervention. Finally, I find it necessary to clarify that, as far as I know, none of the children in said series has been treated or followed up in the *La Paz* hospital of Madrid.

REFERENCE

1. Figueroa MS, Noval S, Contreras I, Arruabarrena C, García-Pérez JL, Sales M, Gil-Cazorla R. Pars plana vitrectomy as anti-inflammatory therapy for intermediate uveitis in children. Arch Soc Esp Oftalmol. 2010;85:390-4.

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Author's reply[☆]

Respuesta de los autores

In relation to the comments¹ on our article titled "Vitrectomy as an anti-inflammatory therapy for intermediate uveitis in children",² we would like to thank the interest in clarifying the best treatments for an infrequent pathology, with management always complicated due to the patients' age, to the high recurrence rate and frequency of complications.

One of the main limitations of our study is its small size, and that it is non-comparative and included only the patients

who needed vitrectomy. A cohort-type study following up the evolution of all patients with intermediate uveitis could have been more illustrative about the adequate management of this pathology.

We consider that, instead of intermediate and posterior inflammation outbreaks after surgery, having recurrences expressing as anterior uveitis which can be controlled with topical treatment is a rather significant result for children in

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whom treatment with periocular or systemic corticoids could give rise to important long-term disorders such as the development of chronic ocular hypertension or metabolism and growth alterations. Recent publications such as "Pars plana vitrectomy in the management of paediatric uveitis: the Massachusetts Eye Research and Surgery Institution experience" or "Pars Plana Vitrectomy versus Immunomodulatory Therapy for Intermediate Uveitis: A Prospective, Randomized Pilot Study" provide additional information that endorses the usefulness of vitrectomy as an anti-inflammatory therapy for these children.

In what concerns the development of cataracts after surgery, we believe this is an acceptable risk. The Group of La Paz found that 11 out of 30 eyes (36.7%) with intermediate uveitis developed cataracts during the evolution of the disease, with 4 (13.3%) requiring surgery. In our view, the slightly higher rate after vitrectomy is acceptable when comparing it with the advantages afforded by said procedure.

The cases were operated on several years ago, when microincisions were not yet established. For this reason, in the discussion section of the paper we expressed our preference for less aggressive techniques instead of 20G vitrectomy.

In our experience, as described in the article, cryotherapy in the same surgical intervention over the lower 180° is enough to control the inflammatory process, although it could effectively be substituted by laser photocoagulation. However, we do not consider that periocular injection at the end of the surgery actually adds any benefits; on the contrary, it could give rise to complications such as ocular hypertension.

Actually, all the patients included in our study were intervened in the Ramón y Cajal University Hospital or in the Ophthalmological Vissum Corporation, both centers in which all the authors have worked or were trained. There is a typo in the references of authors: where it reads: "b *Vissum Ophthalmological Corporation, La Paz University Hospital, Madrid, Spain*" it should read "b *Vissum Ophthalmological Corporation, Madrid, Spain*" as only one of the authors currently works in the La Paz Hospital.

REFERENCE

1. Peralta-Calvo J. De la vitrectomía como terapia antiinflamatoria en la uveítis intermedia. *Arch Soc Esp Oftalmol.* 2011;86: 421-2.
2. Figueroa MS, Noval S, Contreras I, Arruabarrena C, García-Pérez JL, Sales M, et al. Pars plana vitrectomy as anti-inflammatory therapy for intermediate uveitis in children. *Arch Soc Esp Oftalmol.* 2010;85:390-4.

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