Correspondence

Randomized, Controlled, Phase 2 Trial of Povidone-Iodine/ Dexamethasone Ophthalmic Suspension for the Treatment of Adenoviral Conjunctivitis

EDITOR:

WE CONGRATULATE PEPOSE AND ASSOCIATES[1] ON THEIR recent article but note that povidone-iodine/ dexamethasone ophthalmic suspension is not commercially available. Pepose and associates[1] did not mention how this combination was prepared. There is also no mention of the details of the vehicle. Punctate keratitis and subepithelial infiltrate may develop between 6 and 13 days from the onset of the disease and may last for months.[2] Therefore, a follow-up period of 12 days as evaluated by Pepose and associates[1] is too short to evaluate the long-term effects of the drug on the resolution of these lesions. Steroid responders, people with a history of glaucoma, and those with intraocular pressure >21 mm Hg were excluded from the study. However, Pepose and associates[1] have not measured intraocular pressure during the course of the study or in the long term. This raises our concern on the safety profile of the treatment. Their study requires long-term follow-up with a clearly defined control arm before applying the conclusion of the study in our daily clinical practice.

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Cataract Surgery and Rate of Visual Field Progression in Primary Open-Angle Glaucoma

REPLY

WE THANK TUUMINEN AND GRZYBOWSKI FOR THE INTEREST IN our recent article[1] and welcome the opportunity to address their comments.

We agree with Tuuminen and Grzybowski that postoperative transient intraocular pressure (IOP) spikes are common (up to 50% of cases) and potentially harmful events in patients with glaucoma who are undergoing cataract surgery, and we certainly agree that appropriately diligent intraoperative and postoperative surveillance is essential in these patients.[2] Several risk factors have been associated with postoperative IOP spikes in patients with glaucoma, including high preoperative IOP, pseudoexfoliation syndrome, incomplete removal of viscoelastic material, scleral-corneal incision (vs clear corneal incision), inexperienced surgeons, and complicated cases.[2] Our study population was at low risk for postoperative IOP spikes because most of the previously mentioned risk factors were set as exclusion criteria, and all the surgery and postoperative management was performed by an experienced anterior segment surgeon (J.C.). Only 9.8% and 17.4% of eyes had an IOP ≥30 mm Hg or a rise of ≥10 mm Hg on the first postoperative day. Although a postoperative IOP spike might have contributed to the worsening of the visual field (VF) rates, its contribution was likely negligible. Briefly, two main reasons supported this hypothesis: 1) the VF worsening continued over many years after the surgery; and 2) the postoperative VF rates were nearly unchanged in the early postoperative years, and deterioration began years after the surgical intervention. This issue was extensively discussed in our paper.

Tuuminen and Grzybowski argued that the extended follow-up of our retrospective study could have introduced a statistical bias. Glaucoma is a chronic disease, and we believe that the long-term nature of this study is a strength rather than a limitation.

Tuuminen and Grzybowski argued that "more than one visual field device" was used in our study, but this is not true because all VF tests were performed with a Humphrey Visual Field machine (and all IOP readings were measured with Goldmann applanation tonometry). They perhaps meant that VF examinations were obtained with either 30-2 or 24-2 Swedish Interactive Threshold Algorithm standard strategy, but, as detailed in our paper, only the 54 locations of the 30-2 pattern corresponding to the 24-2 test pattern were included in the pointwise analysis. Although global index rates might

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