Letters to the Editor

Influence of serous macular detachment on the efficacy of ranibizumab treatment in retinal vein occlusions

Influencia del desprendimiento seroso macular en la eficacia del tratamiento con ranibizumab en las oclusiones venosas retinianas

Dear Sir:

Venous occlusions are a frequent cause of retinal vascular disease, only exceeded by diabetic retinopathy.1 Macular edema constitutes the main cause of visual acuity loss (VA) and accordingly the therapeutic approach aims at reducing said edema by means of photocoagulation, intravitreal corticoids or surgery. The visual prognosis of this disease has improved due to treatment with intravitreal injections of ranibizumab (Lucentis; Genetech, South San Francisco, CA).2

Optic coherence tomography (OCT) allows ophthalmologists to know that macular serous detachment (MSD) is a frequent tomographic sign in multiple retinal disorders.3 We have developed a prospective pilot study to determine the influence of MSD in the efficacy of ranibizumab intravitreal injection treatment for retinal venous occlusions.

Overall, the study included 49 eyes with retinal branch venous occlusion (RBVO) and 14 eyes with central retinal vein occlusion (CRVO). Measurements were taken of VA (logMAR), retinograph, angiograph and OCT. In the OCT images we analyzed the central retinal thickness values, mean thickness and retinal volume. In addition, we assessed the presence of MSD and its height (Fig. 1). Treatment was initiated with a ranibizumab injection and monthly follow-ups comprising VA measurements and OCT, repeating the treatment due to macular edema or MSD persistence or recurrence (pro re nat). After a mean follow-up of 15.4 months, the following results were determined:

- RBVO Group: baseline VA of patients with MSD (n = 22) and without MSD (n = 27) exhibited significant differences (p = 0.033). After the treatment we observed in both groups a significant VA improvement (p < 0.001). The differences in final VA values in patients with MSD and without MSD were statistically significant (p = 0.001).
- CRVO Group: baseline VA of patients with MSD (n = 7) and without MSD (n = 7) did not exhibit significant differences (p = 0.123). After the treatment we did not observe significant improvements in both groups (p = 0.108 and p = 0.457) respectively. The differences in the final VA of patients with MSD and without MSD were not statistically significant (p = 0.006).

In addition, the correlation analysis between the VA and MSD height baseline variables exhibited a positive correlation (Pearson’s coefficient: 0.384), without this involving a modification of the need of second treatments between patients with and without MSD (p = 0.40). With higher initial MSD values the associated VA was worse.

Fig. 1 – Tomographic section corresponding to an occlusion of the venous branch of the retina with macular edema and macular serous detachment (MSD), showing the characteristic pagoda shape of the MSD (asterisk).

In conclusion, our results suggest that VA in patients with RBVO improved significantly with intravitreal ranibizumab treatment. MSD's constitutes a baseline prognostic factor which entails poor visual results despite the efficacy of the treatment. In patients with CRVO we did not observe significant VA improvements. New studies with larger populations and follow-up time are required to confirm these results in order to define prognostic factors so as to improve and customize the management of patients with RBVO and CRVO.

REFERENCES


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Previous biopsy in the treatment of eyelid carcinomas

Biopsia previa en el tratamiento de carcinomas palpebrales

Dear Sir:

After reading the editorial comment on tendencies in the treatment of periorificial basoscellular carcinomas by García Martín and Fernández Tirado,1 we would like to make a comment we believe could be important and which said authors mention in other publications2 but not specifically in this one, i.e., the importance of previous incisional biopsy. Although with the passage of time the surgical option is the best to eradicate skin carcinoma, there are several conditions that should be taken into account such as the patient age, state of health, lesion location and, size, recurrence, etc. Any malign lesion of the skin could simulate a large number of benign lesions and requires a previous biopsy in order to determine its nature. Incisional biopsy is necessary to establish a histological diagnostic because, even though the majority of ophthalmologists are able to make a correct clinical diagnosis without biopsy, mistakes may arise. Carrying out surgery without an exact histological diagnostic is an unnecessary risk because the ocular globe itself may be unnecessarily compromised, together with adequate cosmetics. In addition, in current treatments2 with topical immunomodulators such as imiquimod and photodynamic therapy a previous histological diagnostic is a requirement,3 simply utilizing a 2 mm diameter trephinator to determine what we are treating and the result thereof. Said treatments are highly efficient and safe, even in locations involving the free palpebral edge.2 In addition, if the application is made with care tolerability is good.

REFERENCES


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