

## Commentary: An insight into the preferred practice of vitreoretinal specialists of India: Surgical retina

With the dawn of technology, our surgical armamentarium has increased by leaps and bounds. Surgeries that were initially considered complex have evolved over time with better success rates. Surgical aspect of retina is unforgiving but provides immense satisfaction to the surgeon to see a previously monocular patient ambulatory or retinal attachment in a patient with complex retinal detachment. To overcome the dilemma of whether to observe or intervene, we need a general consensus regarding the preferred practice pattern and who better to draft it than the prestigious vitreoretinal society of India.

In patients with vitreous haemorrhage secondary to PDR, the age-old adage of observation for at least 3 months before intervention no longer holds true. Partial or complete resolution of vitreous haemorrhage may occur with anti-Vascular endothelial growth factor (VEGF) injections and is essential preoperatively in diabetic retinopathy patients undergoing vitrectomy. Another advancement has been the use of 27-g cutter and bimanual dissection of membranes which have improved the surgical outcomes even in complex tractional retinal detachment.<sup>[1]</sup> Besides preoperative anti-VEGF, preoperative scatter laser at least 3 weeks prior to vitrectomy improves the surgical outcome.

Retinal detachments complicated with choroidal detachment carry a poor prognosis requiring complex vitreoretinal procedure with most surgeons being on the fence regarding drainage of the Choroidal detachment (CD). Initiation of oral steroids as well as use of topical corticosteroids may help in reducing the CD preoperatively. We may even consider depot preparation of corticosteroids in patients who cannot take oral corticosteroids. In patients with inferior retinal detachment with Proliferative vitreoretinopathy (PVR) changes, the classical management involves the use of an encircling band. Although we have seen in patients with inferior RD with PVR grade CP2 or less, a primary vitrectomy without encircling band also provides a good outcome.<sup>[2]</sup>

In surgeries for pathology of the macula, choice of tamponade and extent of Internal limiting membrane (ILM) peeling should be decided on a case-to-case basis. A large flat macular hole of longer duration may require positioning for a longer time with a longer acting gas and air travel may be safely advised to patients having less than 10% gas fill.<sup>[3]</sup> Use of the microscope-integrated Optical coherence tomography (OCT) in surgeries of the macula can help identify iatrogenic full thickness breaks, which is one technology worth investing in. The advantages of the 3D visualization system have been well established through numerous studies.<sup>[4,5]</sup> With the current looming Coronavirus disease-2019 (COVID-19) pandemic, the advantage of the 3D visualization system as a teaching tool needs to be reiterated.

The study published in this issue of the journal provides us with a great outlook into the preferred practices of the many vitreoretinal surgeons of India.<sup>[6]</sup> Although the differences in surgical management may differ due to the lack of availability

of resources as ophthalmic surgery is highly dependent on sophisticated machines. A bigger practice in a metropolitan city can provide a wider range of alternatives for the surgical management of diseases as compared to a small practice in a rural setting. These diversities provide unique challenges to present a unified practice pattern. This study has valiantly tried to overcome these difficulties to provide the preferences of Indian vitreoretinal specialists paving the way for a much more comprehensive practice pattern in the future.

*Atul Kumar, Tavishi Singhal, Nawazish Shaikh*

Dr. Rajendra Prasad Centre for Ophthalmic Sciences, All India Institute of Medical Sciences, New Delhi, India

**Correspondence to:** Dr. Nawazish Shaikh, Senior Resident, Dr. R. P. Centre for Ophthalmic Sciences, AIIMS, New Delhi - 110 029, India.  
E-mail: shaikh.nawazish@gmail.com

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