Response to comment on: Feasibility and safety of vitrectomy under topical anesthesia in an office-based setting

Sir,

We appreciate the authors for their keen interest in our article.[1] We cautiously analyzed their observations and concerns about 27-gauge vitrectomy procedures in an office-based setting[2] and we have the following comments. First, we consider that office-based vitrectomy under topical anesthesia is not only safe for vitreous floaters but these procedures could be excellent tools for prompt, cost-effective evaluation in macular interventions; however, just in a selected group of patients. We ponder, like other authors, that this technique must be performed by an experienced surgeon and in a well-informed and cooperative patient to guarantee adequate surgical outcomes and good safety profile.[3] As the author mentioned, macular procedures represent only a small fraction of the total cases in our series. However, surgical objectives were achieved in all our cases. We recognize that further studies with larger samples are required to establish a conclusion about the safety profile for macular surgeries.

In relation to discomfort of patients during the procedure, it is important to emphasize that pain was reported only during trocar insertion, even though sclerotomies were made in one-step (no beveled) in all cases. Like other authors have mentioned, the most painful moment or discomfort in vitreoretinal procedures is experienced during initial trocar insertion.[4-7] However, the complete surgical experience was not unpleasant, and up to 82.35% of the patients requested the same procedure in the fellow eye.

On the other hand, it is important to clarify that the mean surgical time reported was measured from the insertion procedure until removal of the cannulas. The reduced time registered for our procedures was directly related to case selection. In total, 88.23% of the operated eyes already had vitreous liquefaction and separation, nevertheless, in those cases without this condition, it was easily induced using the vitreous cutter and active aspiration. In this case series, the reported surgical time was enough to effectively achieve all

surgical goals, as no adverse event related to the surgical procedure has been reported at the present time, when all patients have accomplished at least 17-month follow-up period.

Finally, we highly recommend that office-based vitrectomy under topical anesthesia should be consider only in carefully selected cases. Clinical characteristics as well as surgeon's experience are critical variables to contemplate before performing this procedure.

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Conflicts of interest

There are no conflicts of interest.

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