Comment on: Impact of vitreoretinal surgery experience on strabismus surgery performance

Sir,

We read the article, "Learning curves for strabismus surgery in two ophthalmologists" by Kim *et al*. with a great interest.[1] The authors aimed to identify the average turning point by comparing the learning curves of two surgeons learning to perform strabismus surgery. They concluded that approximately fifty cases were required for an ophthalmologist to reach a turning point in strabismus surgery. We congratulate the authors for their lightening study and would like to make some contributions and report a contradiction in the study.

The authors reported that the surgeon A is specialized in the retina and had experience in performing vitrectomy. We know that vitreoretinal surgeons dissect the conjunctiva and tenon tissue for preparing clear scleral base for vitrectomy ports during operation unless they prefer transconjunctival vitrectomy techniques which were learned in last years.[2,3] In addition, a vitreoretinal surgeon commonly performed scleral buckling surgery for retinal detachment treatment. In this surgery, the surgeon has to dissect the conjunctiva and tenon.

Furthermore, they frequently have to find the extraocular muscle around the retinal tear and clear the tenon around it to place the buckling material under the muscle.[4] This means that a vitreoretinal surgeon as surgeon A is familiar with dissecting conjunctiva and finding the extraocular muscles. We think that this was an important factor of a shorter learning curve and shorter operative time of surgeon A. The surgeon A was already had a shorter operative time in first operations [Fig. 1], and this was same at the last cases too. We think that this was due to the advantage of being experienced about conjunctiva and extraocular muscles as a vitreoretinal surgeon.

It is reported that outcomes of a strabismus surgery may also change depending on the patient's, age at the time of surgery, presence of refractive error, and type of strabismus.[5] There was an important difference in age and strabismus type between the cases of surgeon A and B [Table 1]. In addition, the authors did not report if there were any difference in refractive measurements of the cases. We think that all these three factors might be affected the outcomes of the operations.

Finally, the authors reported that the surgeon B had 9 cases of sensory exotropia and 61 cases of intermittent exotropia. However, Table 1 shows 9 cases of intermittent exotropia and 61 cases of sensory exotropia. We think that this error was made by mistake.

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Conflicts of interest

There are no conflicts of interest.

Yakup Aksoy, Abdullah Kaya[1], Mehmet Koray Sevinc[2], Oktay Diner[3]

Department of Ophthalmology, Girne Military Hospital, Girne, Cyprus, [1]Department of Ophthalmology, Anıttepe Military Dispansery, [2]Department of Ophthalmology, Beytepe Military Hospital, Ankara, [3]Department of Ophthalmology, Erzurum Military Hospital, Erzurum, Turkey

Correspondence to: Dr. Yakup Aksoy, Department of Ophthalmology, Girne Military Hospital, Girne, Cyprus. E-mail: dryakupaksoy@gmail.com

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