Response to comment on: Anatomical and functional outcomes one year after vitrectomy and retinal massage for large macular holes

Dear Editor,

Thank you for showing interest[1] in our article on retinal massage for large macular holes.[2]

We agree with your comment that an area of 1.5 DD will be appropriate to facilitate closure. In the initial cases, we took extra effort to ensure the release of all traction caused by internal limiting membrane (ILM), and hence, the larger area of ILM peel. Though we have used the silicone-tipped backflush canula for massaging the retina, a Tano scraper could work as well. Our technique of massage does not involve the area over the papillo-macular bundle in order to avoid any injury to the nerve fibers. This technique can be performed under fluid as well and this may lessen the chance of any injury to the retinal tissue especially for less experienced surgeons. We have used C3F8 gas in our cases but as you have mentioned silicone oil might work as well in select cases. We do agree that fluid gas exchange should be the last step with the fluid drained initially over the disk and then over the hole using a soft tip flute needle with passive extrusion under low intraocular pressure.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient has/have given his consent for his images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity.

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Nil.

Conflicts of interest

There are no conflicts of interest.

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