


The Prevalence and Severity of Acquired Blepharoptosis in US Eye Care Clinic Patients and Their Receptivity to Treatment [Letter]

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Dear editor

We read with keen interest the recently published study titled “The Prevalence and Severity of Acquired Blepharoptosis in US Eye Care Clinic Patients and Their Receptivity to Treatment” authored by MATOSSIAN, Cynthia.¹

Firstly, I would like to express my appreciation for the insightful research presented in the study provides valuable insights into the prevalence of acquired blepharoptosis and the receptivity of eligible patients to pharmacologic treatment with oxymetazoline 0.1% ophthalmic solution. It highlights the importance of patient awareness and early identification of ptosis, which is commendable. However, upon reviewing the literature and considering the context of the study, We believe there is an opportunity to further explore the following aspect:

Firstly, relying solely on patient self-assessment without quantitative measurements by a clinician may lead to inaccuracies.² Patients might overestimate or underestimate the severity of their ptosis based on subjective perceptions or cosmetic concerns. Without objective measurements, such as eyelid margin-to-pupil distance or levator muscle function assessments, the reliability of self-reported data is questionable.³

The study did not include a control group for comparison, which is crucial for establishing the prevalence and severity of acquired blepharoptosis relative to a reference population. Without a control group of individuals without ptosis, it is challenging to determine whether the observed prevalence rates are higher or lower than expected. Additionally, a control group would enable researchers to investigate potential risk factors or associations contributing to the development of ptosis, enhancing the depth of the study’s analysis.^{4,5}

Limited Generalizability of Findings, the study was conducted in a single-center, observational setting, which may limit the generalizability of the findings to broader populations. The sample size was relatively small, consisting of patients from a specific age group (50 years and older) attending a particular eye care clinic. As such, the findings may not be representative of the wider population or reflect variations in ptosis prevalence across different demographic groups or geographic regions. Without a diverse and representative sample, the external validity of the study may be compromised.⁶

Lack of Longitudinal Follow-up, the study was retrospective and cross-sectional in nature, capturing ptosis prevalence at a single time point without longitudinal follow-up. Longitudinal studies tracking patients over time would provide valuable insights into the natural history of acquired blepharoptosis, including progression rates, treatment outcomes, and factors influencing disease trajectory. Without longitudinal data, the study cannot account for changes in ptosis severity or treatment responses over time, limiting the depth of understanding of this condition.⁷

The study does not account for potential confounding factors that could influence patients’ perceptions of ptosis severity. Factors such as age, gender, race, comorbidities, and previous eye surgeries could impact how patients assess their ptosis and their willingness to accept treatment. Without controlling for these variables, the study’s findings may not accurately reflect the true prevalence and receptivity to treatment of acquired blepharoptosis.⁸

We trust that the authors' commitment to advancing ophthalmology will lead to further research and improvements in the field. Your guidance and consideration of these suggestions would be highly valuable in ensuring the study's continued impact and relevance.

Disclosure

The authors report no conflicts of interest in this communication.

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