# Comments on: Management of fovea-involving dry macular fold complicating retinal detachment surgery: Does delayed intervention influence outcome?

Dear Editor,

We read with interest the technique described by Babu *et al*.[1] for the management of a rare post-surgical complication––a fovea involving dry retinal fold. They started with subretinal balanced salt saline (BSS) injection followed by use of perfluorocarbon liquid (PFCL) and diamond-dusted membrane scraper (DDMS) to iron out the fold. This was followed by internal limiting membrane (ILM) peeling, peripheral retinotomy to drain the fluid, retinopexy, and silicon oil tamponade. We wish to report a few modifications which may simplify the process.

Firstly, peeling the ILM before subretinal BSS injection allows for easier peeling and increases the compliance of the retina.[2] This makes the induction of macular detachment by injection of subretinal BSS much easier thereby hiking the probability of opening the retinal fold.[3] Secondly, ILM peeling, macular detachment with BSS followed by FAX opens the retinal fold in most cases.[4] This avoids creation of a posterior retinotomy and need for long-acting tamponade post-operatively. In patients with good RPE function, subretinal BSS gets absorbed in 3-4 days leading to faster visual rehabilitation and avoiding the need for another surgical procedure.[3] Thirdly, in patients with shorter duration of retinal fold, maneuvers like massaging the retina with a DDMS and use of PFCL to flatten the fold may not be required. DDMS itself has the propensity to cause iatrogenic retinal injury and use of excessive instrumentation should be avoided unless absolutely necessary.[5]

We hope a few modifications in the technique will help in making the surgery for this rare complication safer and efficient.

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**Conflicts of interest**

There are no conflicts of interest.

***Simar Rajan Singh, Mohit Dogra***

Advanced Eye Centre, Department of Ophthalmology, Post Graduate Institute of Medical Education and Research, Chandigarh, India

Correspondence to: Dr. Mohit Dogra, Assistant Professor, Advanced Eye Centre, Post Graduate Institute of Medical Education and Research, Chandigarh, India.
E-mail: mohit_dogra_29@hotmail.com

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