

Response to comment on: Sandwich technique using a combination of perfluoropropane and silicone oil for inferior retinal detachment

Sir,

We would like to thank Singh *et al.* for their interest and valuable comments related to our study.^[1,2] Among the four patients, none of the patients had fixed retinal folds i.e., proliferative vitreoretinopathy (PVR) grade C while two patients had

presence of PVR grade B. The study by Tan *et al.* which has been quoted by Singh *et al.* had excluded the patients with inferior retinal breaks between 4 o'clock to 8 o'clock.^[2,3] So a direct extrapolation of their results to our series may not be accurate. In our series, breaks were located in inferior half of fundus in all the patients with case 3 showing multiple inferior breaks, while case 4 was a recurrent retinal detachment with inferior break. We however, agree that cases with primary rhegmatogenous retinal detachment (RRD) with inferior breaks and up to grade B PVR may have a good anatomical outcome even with gas tamponade.^[4] The main advantage with our technique is that postoperative prone positioning may not be required.

Table 1: The preoperative and postoperative details of the patients who underwent sandwich technique (14% C3F8) and silicone oil (1000 cs) injection

Age/gender	BCVA (preop)	Lens status	Location of break	BCVA (postoperative)	Fundus	Follow up
63/female	20/40	Pseudophakic	ITQ	20/125	Retina attached [†]	6 months
69/female	20/80	Pseudophakic	ITQ	20/50	Retina attached [§]	8 months
51/male	CFCF	Phakic	Multiple inferior breaks	20/40	Retina attached [§]	8 months
46/male	20/80	Aphakic [§]	ITQ	CFCF	Retina attached [§]	14 months

[†]Postsilicone oil removal developed re-retinal detachment 4 months after the primary surgery. Subsequently, patient underwent vitrectomy with silicone oil injection and at 2 months post resurgery, retina remained stable, [§]Postsilicone oil removal. ITQ: Inferotemporal quadrant, CFCF: Counting fingers close to face, BCVA: Best-corrected visual acuity

We did not use scleral explants in any of the eyes. In our study, we intended to study the effect of pars plana vitrectomy alone without the use of any additional procedure like scleral explants. Also, segmental explants may not be needed in all inferior breaks related RRD. As already discussed in the paper, the chorioretinal adhesions start forming in the early postoperative period with maximum strength at 2 weeks. So, we hypothesize that by the time of significant recession of the gas bubble, adequate chorioretinal adhesion would have formed to maintain the retina in position. The concern regarding early emulsification has already been listed as one of the limitations in our study. In order to have more detailed information about PVR changes postoperatively, we revisited our cases since a significant time had elapsed after the primary surgery. The clinical details of the patient are shown in Table 1. Case 4 was a case of recurrent retinal detachment with inferior PVR changes. Post sandwich technique, retina remained attached, however, corneal decompensation ensued. During silicone oil removal, pale disc was noted and thus further surgeries were deferred. The corneal decompensation as seen in case 4 may not be directly related to silicone oil since the patient already had multiple vitreoretinal surgery and was left aphakic. Therefore, silicone oil may not be the sole reason for corneal decompensation in this case. The present report is a “proof of concept” pilot study with small sample size. We wish to plan a randomized study with larger sample size and longer follow up for further validation of this surgical approach.

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Nil.

Conflicts of interest

There are no conflicts of interest.

Sumit Randhir Singh^{1,2}, Deven Dhurandhar^{1,2}, Jay Chhablani^{1,2}

¹Academy for Eye Care Education, LV Prasad Eye Institute, Hyderabad, ²Smt. Kanuri Santhamma Centre for Vitreo-Retinal Diseases, LV Prasad Eye Institute, Hyderabad, Telangana, India

Correspondence to: Dr. Jay Chhablani,

Smt. Kanuri Santhamma Centre for Vitreo-Retinal Diseases, LV Prasad Eye Institute, Banjara Hills, Hyderabad - 500 034, Telangana, India.

E-mail: jay.chhablani@gmail.com

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