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Reply

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We thank Dr. Gandhi for his excellently presented comment on our case report. Additional discussion on the validation of clinical features and parameters in complex clinical cases is always welcome and constitutes the most exciting side of academic medicine.

Dr. Gandhi states that the risk profile and the clinical characteristics of our patient strongly support nonarteritic ischemic optic neuropathy. We agree that there were multiple risk factors in our patient that could evoke a number of differential diagnoses.

Dr. Gandhi emphasizes the altitudinal pattern of the visual field defect and the prevalence of a 'disk at risk' which he says to have identified on the delivered photo. However, the scotoma in our patient did

not respect the horizontal line as would be typical of an altitudinal defect. Furthermore, we found no signs of a crowded disk such as small disk diameter (2.9 mm) or drusen in ultrasound examination.

The case series on the association of tumor necrosis factor α antagonists and papillitis that we cited in our report belong to the lowest level of evidence-based medicine. Therefore, Dr. Gandhi has the right to nickname them 'anecdotal'. However, there is a growing awareness and concern of uveitis specialists (expressed on uveitis conferences) about the demyelinating potential of these agents, which surpasses the growing number of cases reported in the literature. This is the case especially for etanercept [1].

The relative coincidence of the optic neuropathy with the start of adalimumab and the fast recovery after discontinuation of the drug make the association of the pathology with the agent most probable.

Reference

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