Dear Editor,

We read with great interest the article by Dutra Medeiros et al. [1] entitled ‘Dexamethasone intravitreal implant for treatment of patients with persistent diabetic macular edema’ published in the March 2014 issue of Ophthalmologica. The authors shared their experience on intravitreal dexamethasone implantation for the treatment of patients with persistent diabetic macular edema (DME). Although there was no clear consensus about the optimal treatment of those patients, we have some important concerns and believe that some key aspects should be emphasized.

First, in the study by Dutra Medeiros et al. [1], there was an incomplete responsiveness and recurrence of macular edema (ME) at 3 months [foveal thickness (FT) >300 μm]; therefore, these patients might need additional treatments. However, the authors preferred to observe them in spite of any intervention. Consequently, the patients with FT >300 μm were left undertreated 3 months after implantation. Besides patient observation, repeated injections can be administered from 3 to 6 months depending on the patients’ individual clinical course.

Second, the patients were followed up only at 3 and 6 months. We believe that this time period is too long. An increase in FT might be seen in some eyes between the third and sixth month, and some eyes might need retreatment before the sixth month. As a result, the evaluation for retreatment should occur <6 months.

Currently, there are no established protocols for the retreatment of ME in DME. In addition, present Ozurdex studies have not directly addressed the question of the optimum retreatment interval in DME [2]. Although DME patients were not included, some recent studies evaluated the role of retreatment with Ozurdex in branch retinal vein occlusion [3, 4]. In the study by Coscas et al. [4], the decision to retreatment was reported to be based on both functional and morphologic criteria, and the authors suggested that retreatment should be considered when visual acuity (VA) deteriorates or if persistent or recurrent ME is documented by optical coherence tomography (OCT).

In the light of those data, the time course and the magnitude of the response to Ozurdex treatment suggest that some eyes are undertreated and that physicians may want to evaluate their patients for retreatment before 6 months. Today, in our clinical practice, many patients are being retreated before 6 months depending on their individual clinical course.

In conclusion, while the findings by Dutra Medeiros et al. [1] are important, some key points should also be emphasized. A complete examination including VA and OCT imaging should be performed 3 months after an Ozurdex injection. According to the findings of the examination, other medical and/or laser treatments should be performed if ME is still present or if VA has decreased. With this strategy, repeated injections can be administered from 3 to 6 months depending on the patients’ individual clinical course.

References
Dear Editor,

We appreciate the comments made by Arıkan Yorgun and Toklu regarding our article [1]. We agree with the authors that there was a partial responsiveness as well as recurrence of macular edema (ME) after 3 months in 32 patients [foveal thickness (FT) ≥300 μm, or evidence of residual edema on OCT, seen as intraretinal cysts or regions of retinal thickening within or outside the central subfield combined with a VA impairment].

The imperative of regular assessments and the objective analysis of the therapy progress provide a basis for clinical decision support. On that basis, any further reinjection as well as other medical and laser-boosting treatment can be specifically tailored according to the patient demands.

Furthermore, clinical trials such as the MEAD study [4] may just partially answer this issue, since all patients who met retreatment eligibility criteria could be retreated every 6 months.

Nonetheless, the time course and magnitude of the response to Ozurdex suggest that some eyes are undertreated and that physicians should evaluate their patients for retreatment earlier (before 6 months) than the current major studies indicate.

Our clinical practice documents several cases that have been tailored to a reinjection procedure after 6 months, according to the patients’ unique clinical course. Despite this, one should emphasize that indications and protocols for reinjections have not yet been accomplished. Hence, it is crucial to achieve a broad consensus regarding this matter.

Moreover, large-scale, randomized, controlled trials addressing and comparing the long-term safety and efficacy of Ozurdex with other treatment modalities are also required to better define accurate therapeutic algorithms [5]. Such treatment options will play an important role in the complex management of DME.

References


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