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CORRESPONDENCE

Feasibility of standalone antitubercular therapy for retinal vasculitis

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To the Editor:
Kelgaonkar and colleagues presented a well-documented case series for cause-specific treatment in tubercular retinal vasculitis (TRV) [1]. The following issues need further discussion:

- The authors, while rightly emphasizing the primary role of antituberculosis treatment (ATT), disputed the rationale for additional corticosteroids. Why then, in cases of greater inflammation (disc/macular oedema, moderate vitreous haze), they preferred corticosteroids? How could the same drug, which delayed TRV resolution in mild inflammation, improve outcome in moderate-severe inflammation?
- The authors laudably based their diagnosis and treatment criteria on clinical appearance, as mandated by classic teaching in uveitis [2]. They however reserved corticosteroids for an alarming clinical subgroup – retinitis - which suggests infectious aetiologies other than TB (e.g., toxoplasmosis, herpetic or other viral aetiologies etc.). Retinitis should probably have been a clinical exclusion criterion, rather than an indication for addition of corticosteroids. They have used the terms "subvascular chorioretinitis" (a selection criterion) and "subvascular retinitis" interchangeably. The term "retinitis" could replace "retinochoroiditis" but not "chorioretinitis." They also encountered 3 cases of extra-vascular retinitis patches, which resolved with "treatment," the details of which have not been furnished.
- While the authors presented excellent clinical criteria to suspect TRV, we need to know from them whether Eales' disease, an isolated retinal vasculitis presumed to represent hypersensitivity reaction to tubercular protein, is the same as TRV as others have averred [3]; or does Eales disease represent a discrete entity to be treated or observed differently.

Dhananjay Shukla [1]✉
[1]*Ratan Jyoti Netralaya, 18 Vikas Nagar, Gwalior 474002, India.*
✉*email: daksh66@gmail.com*

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COMPETING INTERESTS

The author declares no competing interests.

ADDITIONAL INFORMATION

Correspondence and requests for materials should be addressed to Dhananjay Shukla.

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