Author's reply

Dear Editor,

We thank Bansal *et al.*,[1] for their interest in our "practical approach" to medical management of glaucoma and their valid comments. We too agree with their conclusion that "prostaglandin analogues (PGAs) are an important part of the armamentarium in modern medical therapy of most cases of chronic angle closure glaucoma (CACG)." As far as we can gather from a re-read, we never implied that PGA should not be used in angle closure glaucoma. In fact in the "initiation of medication" section we clearly stated that "In an ideal world (not considering cost), we would like to use a prostaglandin analogue in most glaucoma patients as a first line".[2] The authors mentioned the lack of references for some of our statements: that (and more) was dictated by the word limit for the journal. Additionally, while references can usually be found to support most of our biases, their validity is a different issue entirely.[3,4]

To clarify our statements:

1. We stated that "the effect of PGA is inversely proportional to degree of closed angle. The effect of PGA in a totally closed angle is minimal." In our limited experience PG analogues do not reduce intraocular pressure (IOP) in totally (synecially) closed angles as much as in open or partially open angles. As this statement was based on our (admittedly anecdotal) experience (which obviously differs from the anecdotal experience of our colleagues), perhaps we should have used "seems" instead of "is." We are aware of the articles referred to by the authors but do feel they are not definitive either. And while we were part of and agree that the association of international glalucoma societies (AIGS) consensus states that it appears that degree of synechia does not affect the ability of IOP reduction, a consensus has a certain place in evidential hierarchy and "appears" is the key word.
2. "If a patient is on pilocarpine for whatever reason, the effect of PGA on IOP reduction is minimal and other medication (drugs which work on cilliary body) should be used." To agree, or disagree, we should define minimal. From a practical standpoint we feel that the (approximately) 1-2 mm Hg of IOP reduction obtained in such cases may not be clinically significant and we would prefer to try another drug first.[5]

Finally, specialists are known to disagree about details, more so when the evidence is not definitive. Our article was intended for comprehensive ophthalmologists as a practical guide to the medical management of glaucoma; we hope that the lack of major objections indicates some (albeit unstated) support for the objective, the philosophy and principles enunciated.

Rajul S Parikh, Shefali R Parikh[1], Shoba Navin[2], Ellen Arun[3], Ravi Thomas

LV Prasad Eye Institute, Hyderabad, Andhra Pradesh; [1]Sadhuram Eye Hospital, Hyderabad, Andhra Pradesh; [2]Silome Eye Hospital, LV Prasad Eye Institute, Madanpally, Andhra Pradesh, [3]Prime Medical Center, Dubai, India.

Correspondence to Dr. Rajul Parikh, Bomabay City Eye Institute and Research Center, 5 Babulnath Road, Mumbai, India.
E-mail: drparikhs@gmail.com

References

1. Bansal A, Fenerty CH. Practical approach to medical management of glaucoma. Indian J Ophthalmol 2009;57:75-6.
2. Parikh RS, Parikh SR, Navin S, Arun E, Thomas R. Practical approach to medical management of glaucoma. Indian J Ophthalmol 2008;56:218-25.
3. Reigelman RK. Studying a study and testing a test. How to read the medical evidence. Philadelphia: Liipincott, Williams and Wilkins; 2000. p. 16-166.
4. Sackett DL, Haynes RB, Guyatt GH, Tugwell P. Clinical epidemiology. A basic science for clinical medicine. New York: Little, Brown and Co.; 1991. p. 187-248.
5. Higginbotham EJ, Diestelhorst M, Pfeiffer N, Rouland JF, Alm A. The efficacy and safety of unfixed and fixed combinations of latanoprost and other antiglaucoma medications. Surv Ophthalmol 2002;47:S133-40.