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Author's Reply

Dear Editor,

We appreciate the interest shown by the author(s) in our article,[1] and thank them for their valuable comments. We would like to respond to the comments as follows:

Both patients in the case reports were referred to our eye clinic by colleagues in the plastic surgery department after the diagnosis of capillary hemangioma had already been confirmed, and intracranial extension excluded by them. We agree that clinical examination should be combined with other imaging modalities to confirm the diagnosis.

We discontinued treatment in both cases once we had achieved our goal of preventing stimulus deprivation amblyopia, since the posology reported by Luo and Zhao,[2,3] had not yet been published and we were of the opinion that the remaining lesions would undergo further spontaneous resolution over time. We considered the use of a topical beta-blocker to expedite this process,[4] but did not have access to a suitable preparation. The information provided by Luo and Zhao,[2,3] would indeed be very useful if we need to treat similar cases in future.

The reason for not using oral propranolol as first line therapy is simply because of timing. We administered the first intralesional bleomycin injection (IBI) on 13 June 2008, and the landmark article first describing the use of propranolol for the treatment of capillary hemangiomas only appeared after we had completed our research on the topic.[5] Publications in the ophthalmic literature regarding the use of oral propranolol appeared much later.[6,7] We now also routinely use oral propranolol as first line therapy, but maintain that IBI does warrant consideration in patients with capillary hemangiomas, if the use of a beta-blocker is contraindicated for whatever reason.

References

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