

Sir,
Management of macular hole retinal detachment and macular retinoschisis secondary to pathological myopia: a national survey of UK practice patterns

Pathological myopia (PM) is an important cause of visual loss worldwide.¹ Among the spectrum of complications, macular hole retinal detachment (MHRD) and macular retinoschisis (MRS) have been notoriously difficult to manage. Traditionally, treatment involves pars plana vitrectomy (PPV), epiretinal/internal limiting membrane (ILM) peeling with or without gas tamponade. PPV alone, however, does not address the posterior staphyloma. Reported macular hole closure rates with OCT monitoring following PPV vary from 10 to 66%, and retinal reattachment rates vary from 43 to 100%.^{2–4} Reported success rates for MHRD with macular buckling (MB) are encouraging, but the technique has not been widely adopted.⁵ We report on a British and Eire Association of Vitreo Retinal Surgeons (BEAVRS) survey of UK practice patterns for the management of MHRD and MRS in PM over the past 3 years.

Overall, 51/145 (35%) surgeons responded to the survey; 42 carried out at least one procedure for the treatment of MHRD. All used PPV, all used some form of staining for ILM visibility and 73.8% would always attempt ILM peel. All used some form of tamponade with some surgeons using more than one type during the study; 31/42 used C3F8, 8/42 used SF6, 16/42 used silicone oil, and 3/42 used heavy silicone oil. Fifteen out of 33 (45%) surgeons reported primary macular hole closure in >75% of cases and 12/23 (52%) considered that primary retinal reattachment was achieved in >75% of cases. Fifty percent to 86% of participants reported visual improvement in >50% of cases, but only 3/16 (18%) reported a visual improvement of >2 Snellen lines in >75% of cases (Table 1). Overall, 72.5% of participants considered that MB may have a role in the management of MHRD.

Twenty-five undertook at least one procedure for MRS over the past 3 years; all used PPV and one surgeon used MB. All used some form of staining. All used some form of tamponade with some surgeons using more than one type during the study; 16/25 used C3F8, 8/25 used SF6, 5/25 used silicone oil, and 2/25 used heavy silicone oil. Sixty-seven percent of participants reported visual improvement in >50% of cases, but only 3/15 (20%) reported a visual improvement of >2 Snellen lines in >75% of cases (Table 1). The majority (33/45) considered there was no role for MB in the management of MRS.

Despite its limitations, the present survey demonstrates that PPV is virtually the only surgical procedure performed for MHRD and MRS in the United Kingdom and confirms the relatively limited surgical and visual outcomes. The role of MB remains unconfirmed and deserves further study. A nationwide collaborative prospective study with the British Ophthalmic Surveillance Unit and the Royal College of Ophthalmologists is currently being established to determine the incidence of MHRD secondary to PM and number of cases suitable for surgical intervention in the United Kingdom.

Table 1 Anatomical and visual outcomes following primary surgery according to the proportion of cases having treatment for retinal detachment secondary to macular hole (MHRD) and macular retinoschisis (MRS) in pathological myopia

	<50% of cases		50–75% of cases		>75% of cases		Total
	No.	%	No.	%	No.	%	
<i>Anatomical outcomes of MHRD</i>							
Hole closed	4	12.1	14	42.4	15	45.5	33
Hole open (flat/open)	9	40.9	10	45.5	2	9.1	21
Hole open (elevated/open)	11	78.6	2	14.3	1	7.1	14
Primary retinal reattachment	6	26.0	5	21.7	12	52.2	23
<i>Visual outcomes of MHRD</i>							
Visual improvement >2 Snellen lines	8	50.0	5	31.3	3	18.8	16
Visual improvement 0–2 Snellen lines	4	13.8	12	41.4	13	44.8	29
Vision worse	10	81.8	3	18.2	0	0.0	13
<i>Visual outcomes of MRS</i>							
Visual improvement >2 Snellen lines	5	33.3	7	46.7	3	20.0	15
Visual improvement 0–2 Snellen lines	5	33.3	6	40.0	4	26.7	15
Vision worse	8	100.0	0	0.0	0	0.0	8

Conflict of interest

The authors declare no conflict of interest.

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H Lavers and H Zambarakji

The Eye Treatment Centre, Whipps Cross University Hospital, Barts Health NHS Trust, London, UK
E-mail: Heidi.Lavers2@bartshealth.nhs.uk

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