Dermatological review subsequently discovered reddish patches on her anterior chest, with biopsy showing an identical histological diagnosis.

Comment

To the best of our knowledge, this is the first report of folliculotropic MF to affect the peri-ocular skin. Ophthalmic manifestations of mycosis fungoides have shown that late plaque or tumour phase MF affected the eyelids in a significant number of patients.[1] MF can present clinically with lower eyelash and eyebrow loss[2] as in our case. The significance of folliculotropic MF is that it carries a worse prognosis compared to conventional plaque stage MF and therefore important to distinguish histologically.[3] From a practical perspective, oculoplastic surgeons carry out a large number of cosmetic blepharoplasty procedures. Sending every blepharoplasty specimen for routine histological analysis would not constitute wise use of the histopathology service. However, this case serves to illustrate the point that any eyelid skin that is deemed to be even faintly abnormal during examination or during the surgical procedure should be sent for histopathological examination to exclude serious pathology, of the kind identified in this case.

The study was performed in accordance with the declaration of Helsinki. The patient consented to an identifiable photograph of the eyes to be used for publication. The signed consent is in the medical notes.

Conflict of interest

The authors declare no conflict of interest.

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HS Mudhar[1], N Tiffin[2], Z Currie[3] and S Salvi[3]

[1]National Specialist Ophthalmic Pathology Service (NSOPS), Department of Histopathology, Royal Hallamshire Hospital, Sheffield, UK
[2]Department of Histopathology, Royal Hallamshire Hospital, Sheffield, UK
[3]Department of Ophthalmology, A-Floor, Royal Hallamshire Hospital, Sheffield, UK
E-mail: hardeep.mudhar@sth.nhs.uk

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Sir,

Local safety of repeated intravitreal Ozurdex

The article entitled 'Twelve-month experience with Ozurdex for the treatment of macular edema associated with retinal vein occlusion'[1] highlights the significant cataract progression in eyes receiving more than one Ozurdex implant. We retrospectively reviewed the charts of all patients with macular edema secondary to retinal vein occlusion (RVO) refractory to current therapies and treated with Ozurdex from April 2010 until March 2012.

The mean age of patients with branch RVO ($n=33$) was 72.4. In eyes receiving a second Ozurdex implant, four out of the five phakic eyes showed progression of cataract requiring surgery. We registered one case of anterior chamber migration resulting in a bullous keratopathy.[2] The mean age of patients with CRVO ($n=23$) was 68.3. In eye receiving a second Ozurdex implant, four out of the six phakic eyes showed progression of cataract requiring surgery.

Real-life studies are necessary in order to better define the safety and efficacy of new therapeutic approaches. Although the GENEVA study[3] reported an incidence of 29.8% of cataract progression in eyes receiving a second Ozurdex intravitreal implant, Mayer *et al*[1] found a significant higher proportion of these eyes in their study after a third implant (50.0%), and we also evidenced a higher progression of lens opacity in patients with macular edema secondary to RVO refractory to conventional therapies receiving a second implant (75.0% in branch RVO and 66.7% in central RVO). These data should be taken into account when an individualized strategy is planned for patients with RVO.

Conflict of interest

The authors declare no conflict of interest.

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All the authors conceived and designed the work that led to the submission, acquired data, playing an important role in interpreting the results, drafted the manuscript and approved the final version.

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P Hernández-Martínez[1], R Gallego-Pinazo[1], S Martínez-Castillo[1], R Dolz-Marco[1] and M Díaz-Llopis[1,2]

[1]Department of Ophthalmology, University and Polytechnic Hospital La Fe, Valencia, Spain
[2]Faculty of Medicine, University of Valencia, Valencia, Spain
E-mail: pablooftalmologia@yahoo.es

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Sir,
Response to Hernández-Martínez *et al*

This article has been corrected since Advance Online Publication and a corrigendum is also printed in this issue

The letter 'Local safety of repeated intravitreal Ozurdex' by Hernández-Martinez *et al*[1] highlights the impact of intravitreal Dexamethason-implant (Ozurdex) on lens opacification. They showed in a retrospective review that four out of five (BRVO) or six (CRVO) eyes receiving a second Ozurdex showed a progression of cataract requiring surgery. As the Geneva study has shown,[2] Ozurdex is an effective treatment option for macular edema due to RVO. While our study[3] confirms these data, it furthermore shows a significant progression in cataract formation after the third intravitreal injection. Therefore, it is mandatory to consider along with age and intraocular pressure the lens status when using intravitreal Ozurdex. In the mentioned retrospective case series by Hernández-Martinez *et al*, it is not clear whether there is a progression of an existing cataract to a cataract requiring surgery or clear lenses showing a beginning of cataract formation. Furthermore, no objective classification of lens opacification was assessed to show which kind of lens opacification shows a significant progression requiring surgery. It is also necessary to investigate recurrence rates, treatment intervals and the data should be supplemented by a clear follow-up time. We agree that long-term follow-up data are needed to confirm present observations. As the adequate treatment of macular edema due to RVO is still a challenge, treatment possibilities including intravitreal steroids, anti-VEGF substances, laser photocoagulation or combinations are safe and effective options after taking into account the pathogenesis of retinal vein occlusion.

Conflict of interest

The author declares no conflict of interest.

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WJ Mayer, A Wolf, M Kernt, D Kook, A Kampik, M Ulbig and C Haritoglou

Department of Ophthalmology, Ludwig-Maximilians University, Munich, Germany
E-mail: wolfgang.j.mayer@med.uni-muenchen.de

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Sir,
Interval censoring and competing risks when reporting results of glaucoma surgery

Dr Dulku[1] criticised the Kaplan–Meier analysis that Drs Anand and Wechsler[2] used to assess failure and complications after deep sclerectomy with mitomycin C in eyes with failed glaucoma surgery, pseudophakia, or both. He pointed out that these events had occurred at unknown times before the visit at which they were recorded, making the survival curves too good, and recommended that interval censoring[3] adjust for this bias. However, competing risk bias should additionally be considered.

Drs Anand and Wechsler operated on 82 patients,[2] who were on average 76 years old. A total of 20 patients died during the over 5-year-long observation period.[2] The authors do not mention how they dealt statistically with patients who died.[2] We dare expect they were censored just like the patients who became too ill to attend their clinic.[2] However, a fundamental difference exists between these two groups: only the latter group of patients remained at risk after censoring.

After censoring, the Kaplan–Meier curve will drop proportionately more with any subsequent event as compared with what it would have dropped had censoring not taken place. A key assumption is that censoring is independent of the risk of experiencing the event of interest, that is, the risk is equal before and after censoring.[4] Clearly, this assumption is not met if any subjects die: the survival curve will become too pessimistic. Death is a competing risk event, which should be dealt with methods other than censoring,[5,6] such as cumulative incidence analysis,[7] found both in the