All investigators have shared the same conclusion that the risk of substantial ocular morbidity from bleeding after vitreoretinal surgery in patients who are also undergoing antiplatelet or anticoagulation treatment is low. As our study found, the frequency of antiplatelet use is increasing, and most vitreoretinal surgeons have come to realize that their use may not always rest on definitive, evidence-based indications, implying that their discontinuance is less risky. Nevertheless, the ophthalmologist should work in concert with the patient’s medical doctor to determine when the risk of withholding such medications presents an undue risk of much higher systemic morbidity. We believe that proceeding to surgery in such cases can be pursued safely in the vast majority of patients.

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CONFLICT OF INTEREST DISCLOSURES: SEE THE ORIGINAL article1 for any disclosures of the authors.

REFERENCES

Facial Nerve Injury: A Complication of Superficial Temporal Artery Biopsy

EDITOR:
WE READ WITH GREAT INTEREST THE RECENT REPORT BY Yoon and associates describing 4 patients with iatrogenic facial nerve injury sustained during temporal artery biopsy. They correctly describe the danger zone involving the area traversed by the frontal branch of the superficial temporal artery as being a site where facial nerve injury is possible if careful surgical dissection is not performed. We would like to share our preferred method of temporal artery biopsy that decreases the risk of facial nerve injury and improves the cosmetic appearance of the resultant scar without increasing surgical duration.

Like Yoon and associates, we prefer to biopsy the parietal branch of the superficial temporal artery within the hair line, after either palpation or Doppler ultrasound confirms the course of the vessel that is marked before surgery. We agree that this decreases the risk of possible facial nerve injury and leaves a hidden resultant scar. A difference in our technique is that we do not shave any hair. We simply use bacitracin ointment to part the hair at the surgical mark, and proceed with our dissection. We find that the hair does not complicate the surgical dissection or wound closure using this method and that this saves the patient from having a bald patch in the postoperative period. Female patients are especially appreciative of this benefit.

In summary, we agree with Yoon and associates’ suggestion that all surgeons biopsy the parietal, rather than the frontal, branch of the superficial temporal artery to avoid potential facial nerve injury. We also suggest to the readership that placing the surgical incision completely within the hair line, after parting the hair with ointment, allows less risk of facial nerve injury and results in a hidden postoperative scar without a bald patch in the postoperative period. This technique, in our experience, takes approximately 20 to 30 minutes and is accomplished safely with monitored anesthesia care sedation.

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REFERENCE
quences of hair removal are trivial, and certainly less serious than failure to obtain an adequate biopsy specimen. One should not hesitate to remove the hair if necessary, but we agree this step can be omitted in many cases.

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Risk Factors for Development of Choroidal Detachment After Scleral Buckling Procedure

EDITOR:
WE READ WITH SPECIAL INTEREST THE ARTICLE BY AURIOL and associates describing risk factors for development of choroidal detachment after sclera buckling.1 Some points need to be addressed.

Apposition of the retina to the retinal pigment epithelium may be achieved not only by buckling or intraocular tamponade, but also by drainage of subretinal fluid. Also, the authors refer to scleral buckling and an encircling band interchangeably, whereas most surgeons do not use an encircling band in all scleral buckle cases, often performing segmental buckles without banding. The primary purposes of a band are to provide support to retinal tears in different quadrants by creating a circumferential buckling effect and probably in some cases to relieve vitreoretinal traction circumferentially. Normally, regulation of intraocular pressure after subretinal fluid drainage is not among them.

Reference 14 in the article, which is cited to support a rate of choroidal hemorrhagic and or serous detachment of 23% to 44%, is a review article that cites original references dating from 1975 and 1966 that refer only to serous choroidal detachments.2–4 Also, surgical techniques in that era were different from what generally is performed now, so these statistics are not valid today.

The authors lump together serous, serosanguineous, and hemorrhagic choroidal detachments. The pathophysiologic features of serous and hemorrhagic choroidal detachment often are different.5 Serous detachments generally are related to ocular hypotony or inflammation. Hemorrhagic detachments also may occur as a result of hypotony, but risk factors also include trauma, particularly the surgical trauma of choroidal perforation, systemic hypertension, glaucoma, age, and high myopia.5

This series of 69 consecutive rhegmatogenous retinal detachment cases all underwent drainage of subretinal fluid. Many retinal surgeons try not to perform drainage if possible; it is the riskiest maneuver during buckling surgery because choroidal perforation may hemorrhage, and also drainage of subretinal fluid may be accompanied by intraoperative hypotony. Furthermore, the authors do not state how they restored intraocular pressure if the volume of subretinal fluid drained was greater than the buckle volume. Do they simply tighten the band excessively? The authors claim no intraoperative hypotonia was observed, even though all cases were drained; this is ideal, but how was it avoided?

Ten hemorrhagic choroidal detachments from 69 cases is a very high incidence. Further, trans-scleral cryopexy under microscopic visualization was performed in all cases, but this is rarely performed outside of Europe and is a much more difficult technique than cryopexy with indirect ophthalmoscopy. Indirect ophthalmoscopy is the gold standard for sclera buckling in most of the world.

The Discussion states: “The objective of this study was thus to identify conditions leading to the formation of choroidal detachment during sclera buckling surgery...” However, the authors previously state that the principal outcome measure was intraoperative systolic arterial blood pressure. Clearly, the principal outcome measure was selected after analysis of the data and not before, and thus this is not proper statistical procedure.

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