

glaucoma drops and their preservatives as a possible factor in the development of postoperative CME.

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REPLY: Thank you for sharing the interesting results of your study. We agree that the etiology and associated risk factors for the development of CME continue to be perplexing. In our study, multivariate regression analysis was performed for all types of glaucoma drops, including timolol, brimonidine, carbonic anhydrase inhibitor as well as prostaglandin analogs. We found a statistically significant difference only in patients who were using prostaglandin analogs. The difference in results between our studies may be because the prostaglandin drops were not stopped preoperatively or postoperatively in our study, whereas the drops were stopped immediately postoperatively in Feibel's study. Continued investigation into the role of glaucoma drops and the development of CME will help guide cataract surgeons in the perioperative use of prostaglandins.—*Bonnie An Henderson, MD*

LASIK stromal versus epithelial herpetic keratitis

The title of the article by de Rojas Silva et al.¹ includes the general term "ocular herpes," which may include blepharitis, conjunctivitis, epithelial keratitis, stromal keratitis, endotheliitis, and even chorioretinitis and optic neuritis. The inclusion of many variants of ocular herpes in the study and the absence of eyes with stromal keratitis is important to emphasize, particularly when the major concern of refractive surgeons has been stromal disease in patients with a history of ocular herpes. Cases of herpes reactivation after excimer laser surgery have included patients with stromal involvement and have involved severe complications, such as corneal perforation.^{2,3} I think the favorable results of de Rojas Silva et al. may largely be due to the absence of stromal involvement in their study population, which included, for example, 17 cases of herpes blepharitis only and 28

eyes with herpetic keratitis with purely epithelial involvement.

Reports of recurrence of herpetic keratitis after cataract surgery⁴ and intravitreal injection of triamcinolone acetonide⁵ in patients with prior stromal keratitis reinforce the notion that surgical trauma and steroids may play a role in recurrent disease. If a patient experiences epithelial herpetic keratitis soon after LASIK, steroids should be discontinued until the epithelial defect has healed completely, as the clinical course in an operated eye and recent frequent use of topical steroids can be unpredictable.³

In conclusion, the risk for herpetic disease recurrence discussed in the study by de Rojas Silva et al. needs to be carefully interpreted in the context of non-stromal herpetic keratitis. The study does not address the risk for recurrent herpetic keratitis after LASIK in eyes with previous stromal keratitis, and it still seems wise to avoid LASIK in such patients.

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REPLY: In his letter, Mohammadpour emphasizes the absence of stromal involvement as an important point to consider when interpreting the favorable results in our study. Certainly, the results of the Herpetic Eye Disease Study Group¹ have shown that among patients who experienced active ocular herpes simplex virus disease in the previous year, a history of epithelial keratitis was not a risk factor for recurrent epithelial keratitis. In contrast, previous, especially multiple, episodes of stromal keratitis markedly increased the probability of subsequent stromal keratitis. We agree with Mohammadpour's view and, in fact, remarked on the absence of stromal involvement as an important point in the selection of candidates for LASIK surgery in the abstract and discussion section of the article.