evaluate the 3-point measurement (OCT-CET3) stemmed from our clinical observation that CET could vary within the central 2 mm zone in eyes with sectoral LSCD and the 1-point measurement (OCT-CET1) might not be as accurate.

We showed that the inter-observer measurements of CET were highly consistent (<5% variation) between the 2 masked observers. We calculated the repeatability coefficient of OCT-CET1 and OCT-CET3 measurements to be 11.15 μm and 3.58 μm, respectively. The intraclass correlation coefficient of OCT-CET1 and OCT-CET3 was 0.859 and 0.985, respectively. These results support a higher degree of reliability and smaller measurement error of OCT-CET3 than OCT-CET1.

Limit of Agreement (LOA) would be necessary if the purpose of the study was to establish OCT as a surrogate of a gold standard test. We did not consider IVCM as the gold standard for CET measurement but as a control. Nevertheless, we performed the analysis and found that LOA of OCT-CET1 was larger than that of OCT-CET3 (-11.96 ± 11.61 μm vs -9.78 ± 9.67 μm), which is consistent with the correlation analysis.

The area under the receiver operator characteristics curve (AUC) of OCT-CET3 was evaluated in our study, which was higher than that of the maximum limbal epithelial thickness in all four limbal regions. The AUC of OCT-CET1 (0.932) and IVCM-CET (0.911) were smaller than that of OCT-CET3 (0.973), which supports our conclusion that OCT-CET3 is a reliable value of CET as a diagnostic parameter to confirm LSCD.

We agree with Dr. Wan and colleague that appropriate statistical analyses is necessary to support the conclusion of all research. In depth knowledge of the subject of investigation and correct data acquisition are equally important in conducting a sound and meaningful study.

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A Lesson Not To Be Forgotten. Ophthalmologists in Northern Italy Become Internists During the SARS-CoV-2 Pandemic

EDITOR:

IMPORTANT LESSONS TAUGHT TO US BY DR. LI WENLIANG of Wuhan, China, the ophthalmologist who first sounded the alarm over new coronavirus infections, must not be forgotten.[1] Ophthalmologists from around the world have been inspired by his sacrifice, and many have followed his lead by caring for severely ill patients during the coronavirus 2019 (COVID-19) pandemic.

The Lombardy region in Northern Italy was hit particularly hard by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) pandemic during the first quarter of 2020.[2] On March 11, the San Raffaele hospital in Milan was bursting with COVID-19 patients when the Chairman of Ophthalmology, Professor Francesco Bandello, invited department members to join the primary care efforts. By that time, the workload within the ophthalmology department was significantly reduced, and many of us, unaccustomed to such light workloads, were feeling useless. In our hearts, we knew what had to be done.

The decision to join the front-line efforts was not easy, but 11 of the ophthalmology residents volunteered to care for COVID-19 patients. To acquire the necessary knowledge and skills for this task, we quickly reviewed old internal medicine and pulmonary textbooks, researched the newest information about the coronavirus, and learned the correct use of personal protective equipment. Confronted by the daunting task ahead of us, 2 things frightened us, first, becoming infected with the virus, and second and more importantly, not providing proper care to our patients. As ophthalmologists, most of the care we deliver is for non-life-threatening conditions, but patients in the COVID-19 units are critically ill with numerous serious comorbidities. We were unaccustomed to administering oxygen, managing noninvasive and invasive ventilation, and interpreting arterial blood gases of patients with severe interstitial pneumonia.

At the time of this writing, we appear to have moved beyond the peak of the mortality curve,[3,4] and we are beginning to see light at the end of the tunnel. Those of us who worked with COVID-19 patients hope to become eye doctors again soon, but we will be forever proud that we helped during this emergency. When we became doctors, we swore an oath to provide care during a medical emergency or in case of a calamity, but this was not the

only factor that influenced our decisions. We are physicians, but more importantly, we are compassionate humans. Caring for desperately ill patients was our way of helping our families and friends as well as our medical colleagues who shouldered unbearable workloads. We chose to help society and our nation in whatever way we could because we are more than eye doctors, we are physicians.

Some of our COVID-19 patients had ocular surface conditions or other ophthalmic pathologies.[5] One of our ophthalmology colleagues related a nice anecdote that brilliantly summarized our point of view. At the end of a 12-hour shift in the emergency department, he said, "I've had to manage patients with respiratory distress all day long. It was great. But the most satisfying moment of the day was when I corrected the eye therapy of 1 of the COVID patients. She suffered from glaucoma, and she instilled prostaglandin eye drops twice a day. How pleased I was to tell her to use them only in the evening!"

Like Dr. Li, we cared for these gravely ill patients because we are more than eye doctors, but throughout it all, we are proud to be ophthalmologists, and we look forward to returning to providing full-time eye care.

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