error of ±0.5 mm Hg, this was considered to be very stringent, and studies have reported only 0% to10.3% of GAT in institutions fall within this range.[2,3] The clinically acceptable calibration error range was less than ±2.5 mm Hg.[3] If the latter was followed, then that might affect the outcome of this study significantly. Second, interobserver variability for GAT has been reported to be up to 4 mm Hg.[4,5] We believed choosing >4 mm Hg as the standard would reveal the real disagreement beyond the interobserver test-retest variability.

We agree with the authors that IOP is just a surrogate measurement of glaucoma and that we need to consider the entire picture, such as structural and functional changes, before making any major decisions.

ABHIPSA SAHU
VINOTH ARUNAACHALAM
PREMANAND CHANDRAN
GANESH V. RAMAN
Coimbatore, Tamil Nadu, India

ALL AUTHORS HAVE COMPLETED AND SUBMITTED THE ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

REFERENCES

1. Mihailovic A, Varadaraj V, Ramulu PY, Friedman DS. Evaluating Goldmann applanation tonometry intraocular pressure measurement agreement between ophthalmic technicians and physicians. *Am J Ophthalmol* 2020;219:170–176.
2. Choudhari NS, George R, Baskaran M, Vijaya L, Dudeja N. Measurement of Goldmann applanation tonometer calibration error. *Ophthalmology* 2009;116(1):3–8.
3. Sandhu SS, Chattopadhyay S, Birch MK, Ray-Chaudhuri N. Frequency of Goldmann Applanation tonometer calibration error checks. *J Glaucoma* 2005;14(3):215–218.
4. Whitacre MM, Stein R. Sources of error with use of Goldmann-type tonometers. *Surv Ophthalmol* 1993;38(1):1–30.
5. Pearce JG, Maddess T. The clinical interpretation of changes in intraocular pressure measurements using Goldmann applanation tonometry: a review. *J Glaucoma* 2019;28(4):302–306.

Reply to Comment on: Evaluating Goldmann Applanation Tonometry Intraocular Pressure Measurement Agreement Between Ophthalmic Technicians and Physicians

EDITOR:

WE APPRECIATE THE THOUGHTFUL COMMENTS OF DR. SHU and associates. The authors raise the concern that circadian rhythm may have partly contributed to the differences in intraocular pressure (IOP) when comparing clinicians to technicians. While it is theoretically possible, we doubt that this would have been the case in the present study as patients were evaluated by physicians within a short time of being screened by technicians. Although we did not collect data for the exact amount of time elapsed between IOP measurements taken by the technician and those taken by the physician, the longest it would have been was an hour, and most subjects would have been seen within minutes.

The authors also raise a concern about the calibration of tonometers in our clinics. We log these calibrations weekly, and all tonometers must meet a calibration error of ±0.5 mm Hg or they are sent for repair.

Finally, the authors suggest that random noise can produce differences of ±2 mm Hg when measuring IOP and suggest that a more appropriate cutoff value for the study would have been a difference of >4 mm Hg. Although these larger fluctuations are sometimes seen, we continue to believe that differences >2 mm Hg are important from a clinical standpoint and could result in altered treatment plans in some cases.

Once again, we thank Dr. Sahu and associates for raising these important considerations.

DAVID S. FRIEDMAN
PRADEEP Y. RAMULU
ALEKSANDRA MIHAILOVIC
VARSHINI VARADARAJ
Baltimore, Maryland, USA

DR. FRIEDMAN IS NOW AT: GLAUCOMA CENTER OF EXCELLence, Massachusetts Eye and Ear, Harvard Medical School, Boston, Massachusetts, USA.

Comment on: Rethinking the Hydroxychloroquine Dosing and Retinopathy Screening Guidelines

EDITOR:

WE READ WITH INTEREST THE STUDY BY BROWNING AND associates[1] and are writing to highlight the highly variable pharmacokinetics of hydroxychloroquine (HCQ) and its potential implications in HCQ-induced retinopathy (HCQR). The authors stated daily dosage was the most important and only modifiable risk factor for HCQR. Despite being the most important risk factor for HCQR, the dose itself does not completely predict HCQ exposure. HCQ has a variable and incomplete absorption (30%-100%).[2] The reported volume of distribution ranges from 153 liters to 47,247 liters.[2,3] HCQ is desethylated to *N*-desethylhydroxychloroquine (the major active metabolite), and 2 other metabolites in common with