an additional information as usual. However, care must be taken, as the Nd:YAG capsulotomy rate itself is not a useful parameter when evaluating PCO development. Not only the lack of a standardized medical indication but also a variety of factors can influence the final decision on a Nd:YAG capsulotomy: Is it based on only visual symptoms of the patient, definition of decreased vision, ability to perform a YAG capsulotomy, economic reasons, etc. In the present study we tried to minimize indication bias by using a decrease in best-corrected visual acuity to >0.1 logMAR and subjective patient complaints of photic symptoms or reduced visual acuity.

Even in our study population, where patients were instructed and urged to come back to our department in case of visual complaints, we were not capable to see all patients before their YAG capsulotomy; but some still had it done at external ophthalmic offices, with no information for which indication (ie, for a correct indication). So what about the cited retrospective studies with varying sites, practitioners, ill-defined indications, variable postoperative time, and so forth? Isn't the need for an objective factor like PCO and a prospective randomized controlled study design with an intraindividual comparison obvious?

To demonstrate the inferiority of YAG rates as an index for PCO performance, here is an example taken out of the cited studies by the authors of the comment: a YAG rate of 3.7% (Acrysof) and 7.8% (Tecnis) after 1 year (Horn et al, presented poster; No 2 in the table) and on the other hand 2.4% (Acrysof) and 5.1% (Tecnis) after 3 years (Ursell et al; No 1 in the table). We are all entitled to our own opinion on this.

To conclude, one must distinguish between evidence-based studies and "real-world studies." The current study was carried out using an established objective and sophisticated method for the assessment of PCO—prospective intraindividual comparison of 2 different IOLs in a randomized controlled trial using objective evaluation of PCO as the main outcome.

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

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Comment on: Nonexudative Perifoveal Vascular Anomalous Complex: The Subclinical Stage of Perifoveal Exudative Vascular Anomalous Complex?

EDITOR:

IT WAS WITH GREAT INTEREST WE READ THE ARTICLE BY Saconni and associates[1] in which they describe the pre-exudative stage of the exudative perifoveal vascular anomalous complex. The authors describe 6 eyes of 6 patients with nonexudative perifoveal vascular anomalous complex (nePVAC), of whom 4 patients were followed for a mean of 21 ± 14 months. Three of those 4 patients developed exudative PVAC (ePVAC) after 15 ± 9 months. Based on those 3 patients, the authors concluded that nePVAC may represent a pre-exudative stage of ePVAC.

However, as the authors noted as well, spontaneous resolution of exudation may occur in some cases.[2,3] We recently described 21 patients with PVAC after a follow-up of 24 ± 14 months.[4] In 9 of those 21 patients we observed changes in exudation during follow-up. In 2 of 6 patients without exudation at presentation, exudation appeared during follow-up. However, in 7 of 15 patients with exudation at presentation, spontaneous resolution of exudation during follow-up was observed. In 3 of those 7 patients, the PVAC lesion even completely disappeared.

We agree with the authors that nePVAC and ePVAC should be considered part of the same entity, namely PVAC, that warrants monitoring with multimodal imaging. Based on previously published work[2,3] and our data,[4] believe, however, that nePVAC does not have to be a pre-exudative stage of ePVAC, as both appearance and spontaneous resolution of exudation may occur. PVAC is most likely not a stationary disease and may show a sequence of changes. The exudation associated with the PVAC lesion is therefore likely to depend on the moment of time in the evolution of PVAC.

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