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REPLY

WE APPRECIATE THE INTEREST AND POSITIVE FEEDBACK OF Woo and associates. When an iridotomy is placed superiorly, lid coverage is not necessarily protective of visual symptoms, for reasons we discussed in our paper.¹ The superior tear film at the lid margin results in a base-up prism refracting stray light onto the peripheral retina that can result in dysphotopsia. Furthermore, as the lid and tear film is dynamic, visual symptoms may vary considerably.

We agree that linear dysphotopsia is an underreported and potential debilitating complication after laser peripheral iridotomy. Proper informed consent is important for any patient undergoing peripheral iridotomy, and we strongly recommend the iridotomy be placed away from the lid margin to reduce the incidence of dysphotopsia. Thus, we prefer the temporal or nasal location in most cases.

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

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Co-occurrence of Acute Retinal Artery Occlusion and Acute Ischemic Stroke: Diffusion-Weighted Magnetic Resonance Imaging Study

EDITOR:

IN THEIR ARTICLE, “CO-OCCURRENCE OF ACUTE RETINAL artery occlusion and acute ischemic stroke: Diffusion-weighted magnetic resonance imaging study,” Lee and associates recommend emergent evaluation of patients with suspected brain or retinal ischemia.¹ The accompanying editorial, in the wording of its title, “Acute retinal arterial ischemia: An emergency often ignored,” also suggests that

emergency evaluation of these patients is necessary.² Lee and associates make the following points in the discussion of their study:¹

“Recent guidelines from the AHA/ASA recommend that all patients with suspected brain or retinal ischemia should undergo immediate brain imaging and etiological work-ups.³ However, physicians seem to be reluctant to follow these recommendations. According to a recent survey, only 35% of ophthalmologists and 73% of neurologists refer patients with CRAO to the emergency room for extensive etiologic evaluation.⁴”

In the reference cited, the American Heart Association and American Stroke Association do not recommend immediate brain imaging and etiological work-ups of patients with suspected brain or retinal ischemia.³ On the contrary, these guidelines specifically state, “The setting of specific recommendations for the timing and type of diagnostic workup for patients with TIA or stroke is beyond the scope of these guidelines.”³

The survey referenced by the authors, which found that 35% of ophthalmologists refer patients with central retinal artery occlusion to the emergency room, was a study regarding emergency treatment of acute central retinal artery occlusion with thrombolytics.⁴ The survey was not aimed at evaluating the referral of patients with central retinal artery occlusion for etiological evaluation.

Patients with suspected brain or retinal ischemia usually present with symptoms of transient ischemic attack or with signs of acute branch or central retinal artery occlusion. Do the authors have evidence that these patients should be immediately referred for emergency etiological evaluation?

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