Tattoo granulomas with uveitis rather than Vogt-Koyanagi-Harada disease after tattooing?

Dear Editor:

I read with interest the case by Gill et al. about a 32-year-old female who developed bilateral panuveitis associated with simultaneous tattoo.[1] The authors suggested that the patient had probable Vogt-Koyanagi-Harada disease (VKH). The patient did not disclose any of the other classical extraocular features of VKH. I wish to suggest another diagnosis alternative. Regarding the cutaneous symptoms, the article unfortunately lacks clinical pictures, and the authors did not specify whether the rash was restricted to black colour. The skin biopsy showed noncaseating foreign-body granulomas and black exogenous tattoo pigments in the dermis. Based on the anamnesis, the clinical and pathological findings, and the lack of sarcoidosis, I rather think that the patient may have tattoo granulomas with uveitis (TAGU).[2] TAGU is a recent acronym that I suggested after extensively reviewing cases of tattoo granulomas associated with uveitis from the literature.[2] TAGU is an exclusion diagnosis that encompasses patients for whom we fail to find any sarcoidosis or other causes after extensive investigation. The patients are mostly young males with a median age of 27 years who develop bilateral chronic anterior uveitis (81%) or panuveitis (19%). The delay of onset of uveitis varies from 6 months to 12 years after the last tattoo. Cutaneous symptoms present as infiltration, induration, and swelling within the tattoos, mainly on black tattoos (75%). In 70% of the cases, eye and skin symptoms occur almost simultaneously. As in the present case,[1] histology shows nonnecrotizing granulomas surrounding pigmented granules in the dermis. Patients with TAGU are more likely to receive immunosuppressive treatment because of the eye prognosis. The similarities between tattoo granulomas with uveitis and sarcoidosis raise the theoretical question of whether they represent variants of a single biological process. In practical terms, sarcoidosis should be extensively explored with laboratory tests, imaging investigations, and targeted biopsies. We recently informed French ophthalmologists about this rare cause of uveitis.[3] As tattoo is more popular in North America than in Europe,[4] we wish to raise awareness of this condition on the other side of the Atlantic.

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Choroidal thickness changes after cataract surgery

Dear Editor:

We read with great intertest the article titled "Choroidal thickness changes following cataract surgery using swept source optical coherence tomography" by Shahzad et al[1]. We congratulate the authors for their study and for nicely demonstrating the effect of cataract surgery on choroidal thickness with SS-OCT. The authors have concluded that there is an increase in choroidal thickness following cataract extraction at 1-month post-surgery. However, we have a few comments to make.

1) Numerous systemic and local ocular factors can have a bearing on the choroidal thickness. Systemic diseases like diabetes mellitus and hypertension and their changes can affect the choroidal vascular permeability and finally the choroidal thickness[2]. We feel that patients with these systemic problems could have been excluded from the study.
2) The authors in their study have associated the increase in choroidal thickness in the study eyes to post-operative inflammation. However, we feel that in addition to post-operative inflammation, stress and anxiety related to cataract or any ocular surgery and use of topical steroids like dexamethasone can cause choroidal hyperpermeability and subsequently increased choroidal thickness[3].

To conclude, changes in the choroidal thickness following any intraocular surgery are multifactorial. A number of predisposing factors, both systemic and ocular needs to be considered while working on studies related to choroidal thickness.

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Response to Choroidal thickness changes after cataract surgery

Dear Editor:—We would like to thank Venkatesh and Bavaharan for their interest in our work.

1) We agree with their suggestion regarding systemic variables having an impact on choroidal thickness. It has indeed been reported that having certain comorbidities are associated with a change in choroidal thickness. Hypertension is associated with a decrease in choroidal thickness,[1] and diabetes mellites has been found to coexist with a thinner choroid as compared to normal controls.[2] Furthermore, hypercholesteremia and obesity have interestingly been linked with an increase in choroidal thickness.[3,4] However, due to the sample size of our study, we were unable to assess statistically multiple variables which can potentially affect the choroidal thickness. Future studies with larger sample size should take into account systemic factors such as hypertension, diabetes, hyperlipidemia or even states such as pregnancy to evaluate the role of these variables in choroidal thickness change.
2) We also agree that stress and anxiety associated ocular surgery may have a negative impact on choroidal permeability and may affect choroidal thickness change. Future studies in which patients are randomized to topical steroids arm vs non-steroidal anti-inflammatory eye drops can better inform us about the true affect of increased choroidal permeability secondary to steroid drops.

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Vitrectomy in diabetic macular edema

Dear Editor:

We read with great interest the article by Michalewska et al[1] titled "Vitrectomy in the management of diabetic macular edema in treatment-naïve patients". The authors in their study have discussed the advantages of early vitrectomy in diabetic macular edema. However, we have a few comments to make regarding the methodology and the interpretation of results in this study.

1) The authors in this current study do not have a strict visual acuity criterion for including patients in the study. The DRCR.net study evaluating the role of vitrectomy in diabetic macular edema had a well-defined visual acuity criterion [20/63 − 20/400] in their study.[2,3] So, most patients with thicker macula were excluded from their study.