Response to ‘photodynamic therapy for polypoidal choroidal vasculopathy’

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Dear Editor,

In our study, maximum GLD was 6000 μm including the fovea in eyes with PCV. There are several disadvantages associated with PDT, as you mentioned.

In addition, transformation from PCV into polypoidal CNV or secondary CNV development under the retina after PDT during the follow-up study may have been related to PDT. Furthermore, eyes with good visual acuity cannot undergo PDT.

Anti-VEGF drugs are useful for absorbing exudation in eyes with PCV, whether or not polypoidal lesions regress [in our recent study, causative polypoidal lesions disappeared on ICGA in 15% of 26 eyes with visual acuity of 0.6 or more after three treatments with ranibizumab, and mean visual acuity improved from log MAR 0.11 to 0.03 ($P < 0.001$)]. Therefore, PCV patients with good visual acuity

are thought to have a good indication for ranibizumab monotherapy. However, the Everest study showed that the disappearance rate of polypoidal lesions on ICGA was significantly better with PDT alone and PDT plus ranibizumab than with ranibizumab monotherapy (personal communication). Persistent polypoidal lesions may result in recurrent exudation and/or hemorrhage, such that several re-treatments will be needed for recurrent exudation over an extended period.

Therefore, PDT is needed in cases with visual acuity of 0.5 or less. These cases, especially, respond well to PDT, as we have shown in this study.

PCV manifests in various ways, e.g., as a small network with one polypoidal lesion or a large network with multiple polypoidal lesions. In the near future, we plan to choose the best modality based on clinical manifestation.

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