

Drs. Carter and Do reply

To the Editor:

We thank Dr. Martin-Iglesias, *et al* for their comments¹ on our recent case report published in *The Journal*². We reported on a case of hydroxychloroquine (HCQ) retinopathy, and showcased the characteristic optical coherence tomography (OCT) and fundus autofluorescence imaging findings in a patient who had been taking approximately 13.6 mg/kg/day for 8 years, almost triple the recommended dose.

Ethics board approval is not required because this is a single case report and no intervention had been made for research. The patient gave written informed consent to publish the material.

HCQ retinopathy is rare at 0.33% incidence with short-term therapy (< 5–7 yrs)³, especially when treatment follows the American Academy of Ophthalmology (AAO) guideline of doses \leq 5 mg/kg/day⁴. Dr. Martin-Iglesias, *et al*¹ emphasize the point that there is increased risk of toxicity among patients receiving greater doses. In a prior study from this group following a cohort receiving HCQ at \leq 5 mg/kg/day, no clinically significant retinal changes or cases of toxicity were detected by OCT over a 5-year period⁵. These findings align with the AAO-recommended HCQ dosage guideline.

However, duration of therapy relative to daily dose also plays a significant role and is considered a critical factor when screening for HCQ retinopathy⁴. After 10 years of daily HCQ use within the 4–5 mg/kg range, risk of retinopathy increases dramatically⁶. It would be interesting to further follow the study cohort for retinal changes at the decade timepoint and beyond.

Overall, we highlight the comment of Dr. Martin-Iglesias, *et al*¹ that HCQ retinal toxicity is most dependent on daily dose. For those on a high dose, or long-duration HCQ therapy, it is especially important to have regular ophthalmologic screenings.

Kaylene L. Carter^{1,2} , MD, Resident Physician

Diana V. Do¹, MD, Professor of Ophthalmology

¹Byers Eye Institute, Department of Ophthalmology, Stanford University School of Medicine, Stanford, California;

²Department of Internal Medicine, Tower Health Reading Hospital, Reading, Pennsylvania, USA.

Address correspondence to Dr. D. Do, Byers Eye Institute, Department of Ophthalmology, 2452 Watson Court, Palo Alto, California 94303, USA. Email: Dianado@stanford.edu.

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