sight-threatening condition, for which there are no current therapeutic options.

The size and the scope of our article were limited by the nature of a retrospective chart review, which only allows analysis of follow-up that occurred within the defined time frame. Additional factors limiting the scope and length of the study included (1) the logistical and financial complexity involved in following up patients in two geographically separated states; (2) the differences in available equipment in the two institutions; and (3) the importance of sharing a potential new treatment with the ophthalmic community sooner rather than later.

The retrospective chart review process was begun while the senior author was at the University of Florida, and because he moved from Florida to Massachusetts, the analysis was carried out in Massachusetts, and appropriate Institutional Review Board approval from the Massachusetts site was published in the article.

The valproic acid treatment regimen analysed retrospectively in the charts of the seven patients is detailed in the article. Prospective follow-up was not carried out, nor is it allowed under the mandate of a retrospective chart review. To clarify, the treatment of patients with valproic acid has not been stopped for any of the patients who tolerated it well (most of the patients). Our retrospective chart review reported on in the BJO article captured a relatively short period for a slowly progressive condition such as RP, and we recognise that the most rigorous validation of a therapy will be a well-designed clinical trial. A prospective, multicentre, randomised, placebo-controlled clinical trial is in the final stages of preparation[3] in the USA, and we will be registering this clinical trial very soon at the US clinical trials website, http://www.clinicaltrials.gov.

On a separate note, as part of our current clinical practice in Massachusetts, several RP patients new to our practice have been treated with valproic acid; our clinical impressions of these new patients are similar to what was reported in our article.

There is mounting evidence that valproic acid may have potent neuroprotective properties and have other beneficial effects,[4–6] and we have an intensive programme of in vitro and in vivo experiments (including mice models of RP) under way. The results of our experiments in the context of retinal degenerative conditions have been reported at recent meetings.[7–11] We are planning to submit these data as articles to peer-reviewed journals.

Our work has been motivated by the spirit of translational research, with the goal of more quickly identifying a promising therapeutic approach and stimulating scientific interest and further research, based on preclinical data and unexpectedly positive vision function observed in a clinical setting. Repurposing drugs such as valproic acid, which have been shown to be safe, is an economical and time-efficient way to quickly bring new treatments to patients.

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CORRECTIONS

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M A Elgohary, McCluskey PJ, Towler HMA, *et al*. Outcome of phacoemulsification in patients with uveitis. *Br J Ophthalmol* 2007;**91**:916–21. In the previous issue, we listed a correction to the DOI of this article under the DOI: 10.1136/bjo.2006.109660corr1. The correct DOI is 10.1136/bjo.2006.109660; this is the DOI that the article was published with and the correction in the previous issue can be disregarded.

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M A Elgohary, McCluskey PJ, Towler HMA, *et al*. Outcome of phacoemulsification in patients with uveitis. *Br J Ophthalmol* 2007;**91**:916–21. This article was published in triplicate online first under the above DOI. The correct DOI is 10.1136/bjo.2006.109660; this is the DOI that the article was published with.

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Oliveira-Neto MP, Mattos M, Benchimol E, *et al*. Blepharo-conjunctivitis due to Leishmania (Viannia) Braziliensis cutaneous infection: report of two cases in Rio de Janeiro, Brazil. *Br J Ophthalmol* 10.1136/bjo.2006.112128. This article has been withdrawn.

doi:10.1136/bjo.2009.158089corr1

A A Fawzi, N G Lee, D Eliott, *et al*. Retinal findings in patients with Alport Syndrome: expanding the clinical spectrum. *Br J Ophthalmol* 2009;**93**:1606–1611. For case number 9 in table 1 "Family History – No" should say "Family History – Yes".

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M Maia, M E Farah, E B Rodrigues, *et al*. Subretinal Brilliant Blue G migration during internal limiting membrane peeling. *Br J Ophthalmol* 2009;**93**:1687. The order of the authors in this article was published incorrectly; the correct order is: Malerbi FK, Maia M, Farah ME, Rodrigues EB.

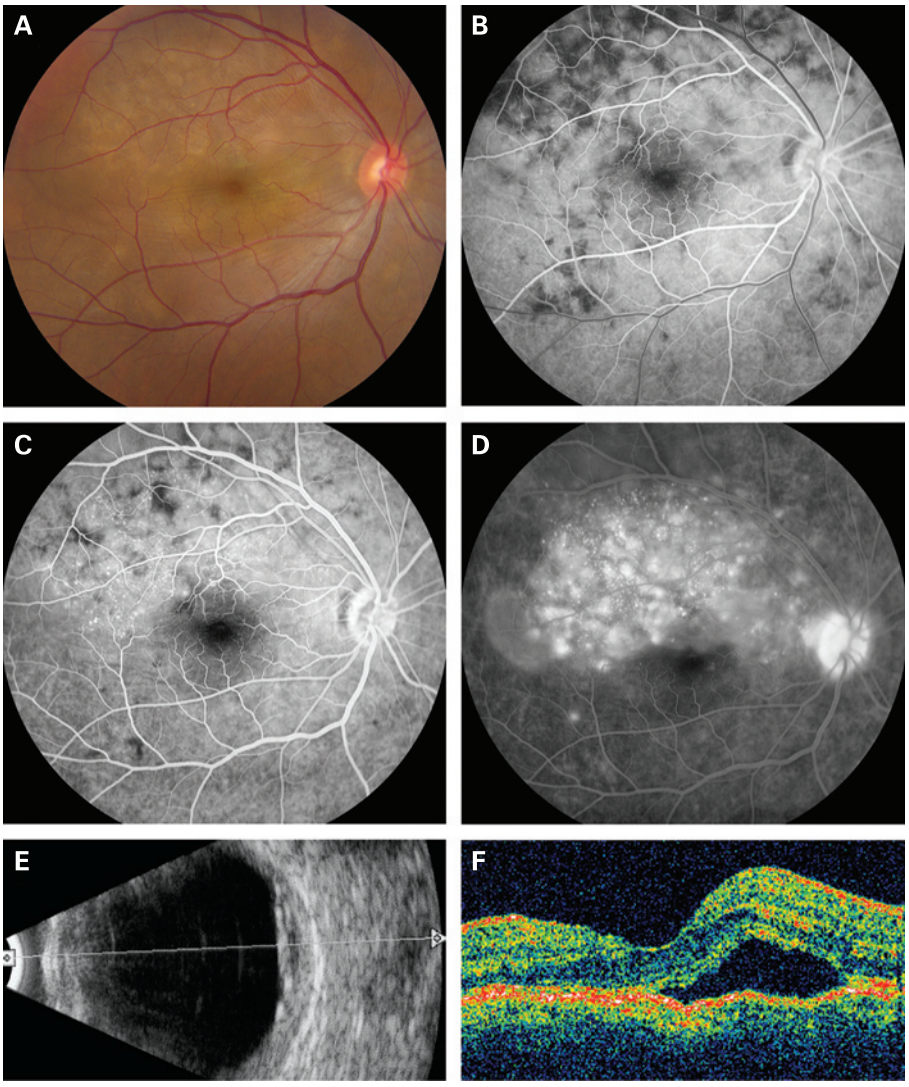

Figure 2 (A) Colour photograph of the right fundus of the patient in case 1 at presentation showing serous macular detachment with underlying choroidal nodules consistent with the diagnosis of Vogt–Koyanagi–Harada disease. (B–D) Fluorescein angiogram of the right eye showing multiple pinpoint leaks under the area of macular detachment followed in late frames by partial filling of the detachment space. (E) B-scan ultrasonography of the same eye showing a shallow serous retinal detachment associated with choroidal thickening, but no evidence of scleritis. (F) Optical coherence tomography (90°) showing neurosensory retinal detachment superior to the fovea.

CASE 3

A 43-year-old man presented with severe headaches and a unilateral panuveitis in the left eye associated with optic disc oedema and a serous retinal detachment involving the macula. The patient was treated with a 2-month course of oral prednisone. Eleven months later, the patient developed recurrent severe headaches and was observed to have a bilateral panuveitis associated with serous macular detachments. B-scan ultrasonography showed choroidal thickening and serous retinal detachment with minimal T-sign in both eyes. The patient was restarted on oral prednisone, resulting in excellent control of ocular inflammation.

DISCUSSION

VKH disease is almost always bilateral with fellow eye involvement at or within several weeks of presentation. Unilateral VKH disease, although rare, has been reported, however. Kouda and colleagues described a 38 year-old woman who was originally diagnosed as having posterior scleritis associated with a serous macular detachment in one eye who, 12 months later, developed bilateral VKH disease.[1] Forster and colleagues also described a 4-year-old boy who presented with unilateral clinical findings consistent with VKH disease, though B-scan ultrasonography showed choroidal thickening in the fellow eye.[2] We have presented three patients with VKH disease who had a significant delay in fellow eye involvement, ranging from 11 months to 6 years. Although typically bilateral, ophthalmologists should be aware that VKH disease may present unilaterally, with significantly delayed fellow eye involvement.

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CORRECTION

doi:10.1136/bjo.2007.114801corr1

The paper by Elgohary *et al* (*Br J Ophthalmol* 2007;**91**:916–21) should have had the doi: 10.1136/bjo.2006.109660. We have corrected the online version.