

**Re: “Open-globe injuries: associated findings, management, and visual outcomes”**

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**Dear Editor,**

We read with great interest the article by Kılıç et al.,<sup>1</sup> which characterizes adult open-globe injuries (OGI), management patterns, and visual outcomes in a single-center cohort. The authors' emphasis on early primary repair and the distribution of anterior/posterior segment findings adds valuable local data to the literature and will be informative for clinicians who support clinical decision-making and patient counseling at presentation.

In this context, we would like to offer several suggestions that may further strengthen the manuscript.

**Prognostic stratification with Ocular Trauma Score (OTS):**

In addition to baseline/final visual acuity and zone-based results, incorporating the OTS would enhance between-study comparability and support clinical decision-making. OTS combines initial acuity with key injury variables [e.g., rupture, endophthalmitis, retinal detachment, relative afferent pupillary defect (RAPD)] to estimate probabilities of final vision categories and is widely adopted in OGI research and practice.<sup>2</sup>

**Time-to-repair granularity within 24 hours:** The manuscript highlights that all primary repairs were completed within the first 24 hours. Reporting finer time bands-e.g., <6 h, 6-12 h, and 12-24 h-and exploring their association with final vision or infection risk would add nuance. Contemporary evidence suggests earlier repair is associated with lower endophthalmitis risk.<sup>3,4</sup>

**Infection prophylaxis reporting:** Detailing systemic and intraocular antibiotic prophylaxis regimens (agents, routes, timing, duration) and tetanus prophylaxis would increase the paper's translational value. Recent reviews indicate heterogeneous practice patterns; while systemic antibiotics are common, intraocular antibiotics at primary repair may have stronger supporting evidence in high-risk scenarios.<sup>5</sup>

**Imaging and intraocular foreign body (IOFB) detection:**

Because management and prognosis hinge on identifying IOFBs, we encourage reporting the usage rates of computed tomography (CT)/ultrasound (US), IOFB detection yield, and how imaging influenced surgical planning. Studies suggest CT is generally the preferred modality for rigid IOFBs, with sensitivity improving for larger fragments.<sup>6</sup>

**Occupational prevention signals:** Given the predominance of metal/wood injuries in many cohorts, specifying occupation categories, rural/urban origin, and personal protective equipment use could yield practical prevention messages for public health and workplace safety stakeholders.

**Generalizability to pediatrics:** Because this series focuses on adults, explicitly stating the limits of generalizability to pediatric OGI would help frame the scope and encourage complementary pediatric analyses.

In summary, Kılıç et al.<sup>1</sup> contribute meaningful data on adult OGI. We believe that adding OTS-based stratification, within-24-hour time-band granularity, explicit prophylaxis details, and imaging/IOFB metrics-supported by targeted analyses-would further enhance the manuscript's impact and its applicability to everyday decision-making.

**ETHICAL DECLARATIONS**

**Peer Review Process**

This letter was externally peer-reviewed.

**Conflict of Interest**

The author declare no conflicts of interest.

**Financial Disclosure**

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## Author Contributions

The author is solely responsible for the conception, data collection, analysis, and writing of this manuscript.

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**Author reply “Open-globe injuries: associated findings, management, and visual outcomes”**

 **Rasit Kılıç**

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**Dear Editor,**

We would like to thank the authors for their thoughtful and constructive comments on our article and for their interest in our work. We appreciate the opportunity to clarify several points and to discuss potential areas for further enhancement. We respond to each comment below.

**Prognostic stratification with the Ocular Trauma Score (OTS):** We agree that the Ocular Trauma Score is a valuable and widely accepted prognostic tool in open globe injury (OGI) research and clinical practice. In our retrospective cohort, several OTS components-most notably relative afferent pupillary defect-were not consistently or reliably documented in the medical records, which precluded accurate post hoc calculation of OTS categories for all patients. For this reason, we focused our analyses on baseline and final visual acuity, injury zones, and major clinical variables that were uniformly available. We fully agree that prospective data collection incorporating complete OTS parameters would enhance between-study comparability and clinical interpretability, and we plan to include OTS-based stratification in future studies.

**Time-to-repair granularity within the first 24 hours:** We appreciate this suggestion. Although all primary repairs were performed within 24 hours, the exact timing from injury to surgery was not recorded with sufficient precision in a substantial proportion of cases to allow reliable subgrouping into narrower time bands (<6 h, 6-12 h, 12-24 h). We acknowledge that increasing evidence supports earlier repair, particularly with respect to reducing the risk of endophthalmitis. This limitation has now been recognized as an important consideration for future prospective investigations.

**Infection prophylaxis reporting:** The authors agree that detailed reporting of prophylactic regimens would increase the translational value of the study. In our clinic, systemic broad-spectrum antibiotics and tetanus prophylaxis are routinely administered according to institutional protocols, while intraocular antibiotics are reserved for selected high-risk cases at the discretion of the operating surgeon. However, due to heterogeneity in agents, dosing, and duration over the long study period, these data were not analyzed separately. We acknowledge this as a limitation and concur that standardized reporting of prophylaxis strategies would be highly valuable in future work.

**Imaging and intraocular foreign body (IOFB) detection:** We agree that identification of IOFBs is critical for management and prognosis. In our cohort, all patients with suspected open globe injury underwent computed tomography (CT) scanning as part of the initial evaluation. CT was the sole imaging modality used for IOFB assessment, and ocular ultrasonography was not performed in any case, in accordance with our institutional protocol and concerns regarding potential globe manipulation in the acute setting.

**Occupational and prevention-related factors:** We appreciate the emphasis on prevention. While the mechanism of injury was recorded, more granular data regarding occupation, rural versus urban setting, and use of personal protective equipment were inconsistently available in the retrospective records. We agree that inclusion of these variables could generate important public health and workplace safety insights and should be prioritized in prospective or registry-based studies.

**Generalizability to pediatric populations:** We agree that pediatric open globe injuries represent a distinct clinical and epidemiologic entity, and the findings of the present study should therefore be interpreted within the context of adult patients only. As explicitly stated in our Methods section, this series was intentionally limited to adults, reflecting differences in injury mechanisms, ocular tissue properties, management strategies, and visual prognosis between adults and children. Importantly, we have previously addressed pediatric globe injuries in a separate, dedicated publication, in which pediatric-specific epidemiological and clinical characteristics were analyzed. We believe that separating adult and pediatric cohorts allows for more accurate interpretation of outcomes within each population and avoids inappropriate extrapolation.

In summary, we thank the authors for their valuable comments, which highlight important directions for future research. We believe our study provides meaningful data on adult OGI outcomes, and we agree that incorporation of OTS-based stratification, finer time-to-repair analyses, standardized prophylaxis reporting, detailed imaging metrics, and prevention-focused variables would further enhance the impact and applicability of this field.

Sincerely,

on behalf of the authors

