ing beam of the laser device. To our knowledge, the described sham techniques have not been validated for use as masked controls for the laser treatment of floaters.

Lastly, I investigator performed all laser procedures and statistical analysis and had full access to all the data in the study, yet the authors assert that the study was masked. It is therefore possible that several biases could have been introduced, including: (1) selection bias (biased allocation to interventions) because of inadequate generation of a randomized sequence and inadequate concealment of allocations prior to assignment; (2) performance bias associated with the investigator’s knowledge of the allocated interventions by participants and personnel during the study; and (3) detection bias associated with the outcome assessors’ knowledge of the allocated interventions.

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To the Editor The negative impact of vitreous floaters is becoming increasingly apparent. Clinically relevant cases with abnormal vitreous structure and degraded contrast sensitivity function can be called vision-degrading vitreopathy to distinguish from insignificant cases. Increasingly, patients with this condition are being offered therapy by various means.

Shah and Heier recently reported neodymium-doped YAG laser treatment of Weiss rings. Throughout their article, the authors use the term vaporize to refer to the changes that YAG laser energy can induce ocular tissues. However, YAG lasers act primarily as photodisruptors and do not vaporize biologic tissues. Experiments show that less than 10% of absorbed laser energy contributes to vaporization, while the remainder is converted to mechanical disruption. The distinction is important because referring to vaporization leads readers to imagine that the retina is rendered clear. In reality, the photodisruptor effect breaks down larger structures into smaller ones that are often not visible using biomicroscopy or fundus photography of the type that Shah and Heier used. These can still potentially still able to disturb vision by degrading contrast sensitivity function.

This may have been the case in the study by Shah and Heier, which reported that “the YAG group reported significantly greater improvement in self-reported floater-related visual disturbance (54%) compared with sham controls (9%).” In addition, the authors report that only 19 patients of 36 treated participants (53%) experienced significantly or completely improved symptoms. Although both findings were statistically better than sham controls, statistical significance does not necessarily equate with clinical significance. In this case, only half of treated participants got better, and those improved only by half.

Furthermore, Shah and Heier used the National Eye Institute’s Visual Functioning Questionnaire–25 to assess treatment outcomes and found results showing little improvement (per their Table 2). After YAG laser treatment, dependency improved only 4.6% and role difficulties 11.5%; near vision improved 5.9%, color vision 2.8%, peripheral vision 5.5%, and distance vision 9.4%. Are improvements of only 2.8% to 11.5% considered clinically relevant? Moreover, could the authors explain why general vision actually worsened by 3.5%, while treatment by limited vitrectomy has exhibited a 34.6% improvement in the same outcome measure in other studies?

The lack of substantial vaporizing by YAG lasers may be an important reason the results were not better. I recommend that patients be made aware that YAG lasers primarily disrupt rather than vaporize biologic tissues, and thus may not yield the desired results. Lastly, only Weiss rings were treated in this study, so the findings may not apply to all vitreous opacities.

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