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LETTER

Efficacy and Safety of Intravitreal Brolucizumab in Chronic Central Serous Chorioretinopathy: A Retrospective Cohort Study [Letter]

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Dear editor

I read with great interest the article by Chakraborty et al[1] evaluating intravitreal brolucizumab in chronic central serous chorioretinopathy (cCSCR). This study contributes to the limited literature on anti-VEGF therapy in cCSCR and highlights encouraging anatomical and functional improvements over twelve months. While the results are promising, several methodological considerations warrant discussion.

First, the retrospective, single-centre design without a control arm limits the ability to attribute improvements solely to brolucizumab. Spontaneous resolution of subretinal fluid can occur in cCSCR beyond four months, and the absence of a comparator such as half-dose photodynamic therapy (PDT) or observation constrains interpretation. Randomised controlled trials directly comparing brolucizumab with PDT, the current reference therapy, are needed to establish relative efficacy.[2] Furthermore, a recent network meta-analysis confirmed PDT as the most effective intervention for chronic disease with anti-VEGF agents achieving some anatomical improvement but performing significantly worse than PDT for fluid resolution and functional outcomes.[3]

Second, the authors are commended for excluding macular neovascularisation (MNV) using OCT angiography (OCTA). Nonetheless, subclinical MNV may have been overlooked, given OCTA's limited sensitivity and segmentation artefacts.[3] Therefore, multimodal imaging, particularly indocyanine green angiography, could have strengthened diagnostic accuracy and ensured that fluid resolution was not attributable to undetected MNV.

Third, the favourable safety profile reported contrasts with the established risks of intraocular inflammation and retinal vasculitis seen with brolucizumab in neovascular age-related macular degeneration.[4] The absence of adverse events over twelve months is reassuring, but rare complications may only emerge in larger or more diverse populations. Prospective multicentre studies with extended follow-up will be essential to define the true risk–benefit balance of off-label use in cCSCR.

Fourth, although visual acuity gains were observed, the study did not assess patient-reported outcomes or quality-of-life measures. Functional disability in cCSCR often stems from metamorphopsia and contrast sensitivity deficits, which are not captured by visual acuity testing. Thus, including such endpoints would provide a more comprehensive assessment of therapeutic benefit.

Finally, the relatively low injection burden (mean 1.7 per eye over one year) compares favourably with prior aflibercept or ranibizumab series, which often required dosing every 6 to 8 weeks in clinical practice.[5] Brolucizumab has demonstrated longer durability and more complete fluid resolution in neovascular AMD, as shown in the HAWK and HARRIER trials.[4] This may explain the reduced reinjection rates observed by Chakraborty et al.[1]

Nonetheless, interpretation requires caution. The small sample size, retrospective design, and lack of comparator group raise the possibility of bias. While reduced treatment burden is desirable, safety remains paramount given the risk

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of intraocular inflammation.[4] Larger controlled studies directly comparing brolucizumab with aflibercept or PDT, and evaluating outcomes in relation to baseline anatomical features, are required.

In conclusion, Chakraborty et al provide valuable data suggesting brolucizumab may achieve durable fluid resolution and visual stability in selected cCSCR cases, particularly where PDT is unavailable. Future prospective trials with rigorous design will be essential to clarify its role within the therapeutic armamentarium for cCSCR.

Disclosure

The author reports no conflicts of interest in this communication.

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