that, there might have been dilution in the standard of peer review process in the face of rapid publication particularly by the paid and upcoming journals. Quality control of publications is possibly taking a back seat in a large number of cases. Getting a good and unbiased review for a manuscript takes time as good reviewers are not in plenty and they have their own commitments. It is the responsibility of a journal to ensure and uphold quality of the review process. Some practical and feasible steps have been elaborated in the article for ensuring a fair and quality review process.¹

Guaranteed publication on a fast track basis in exchange of money is now rampant in the academic circle. Most academicians now receive email invitations almost on a daily basis for submitting article in various journals with a number of lucrative options. The situation was never so dismal earlier. Typically, an anxious young professional desperate for a mandatory publication to ensure career progression, is the usual prey to such journals which can be aptly labeled as 'predatory journal'. The issue of predatory journals has been elaborated in an article by Cariappa et al.²

Another disturbing trend today is that of suggesting alternative sister journal of a particular reputed journal to an author whose manuscripts have not been found to be suitable for that particular reputed journal. Of course, this comes at a cost, as the sister journal happens to be an open access journal that levies publication charges from authors. Does it mean that if an article is found unsuitable in a good journal can find its way to its sister journal at some cost

although it was deemed unsuitable? Unfortunately, so far, there is no known legal recourse against such wrongdoings. The scientific fraternity needs to think seriously on these issues and formulate strategies to combat unethical and substandard publication practices for the sake of humanity.

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Maj Gen A.K. Das^{a,b}

^aDeputy Chairman, Editorial Board, Medical Journal Armed Forces India, Armed Forces Medical College, Pune 411040, India

^bDean and Deputy Commandant, Armed Forces Medical College, Pune 411040, India

E-mail addresses: arup.kr@hotmail.com (A.K. Das)

<http://dx.doi.org/10.1016/j.mjafi.2016.06.010>
0377-1237/

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Letter to the Editor

Dear Editor,

I read with extreme interest the original article titled “A prospective interventional study of effect of accelerated orthokeratology on the corneal curvature and refraction among young adults with myopia” by Khan et al. published in *Med J Armed Forces India* 2016;72:125–130.¹ The article is regarding use of specially designed rigid gas permeable corneal contact lenses to reduce patient's myopia of less than –5.0 D. Myopia is now a major public health problem, and uncorrected refractive error is ranked second as the leading cause of visual impairment in India.² The authors have rightly pointed out that it may be used as an alternative to conventional contact lenses or LASIK surgery for mild to moderate degree of myopia. However, most of the studies carried out on orthokeratology were for halting the progression of myopia in children.³ In a very recent study,⁴ the authors had compiled clinical case series from various online data regarding the safety and side effects of Orthokeratology and also concluded that OrthoK in general is a safe option for myopia correction and retardation. However, I have few queries:

(a) What were the changes in axial length of studied patients?

(b) Were there any decrease in quality of vision in these patients like problem of coloured haloes, glare or decrease in contrast sensitivity?

(c) Being in the armed forces, is there any method by which we can detect recruits/cadets who come for medical examination using these lenses in order to correct their myopia and thwart the visual standards?

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Wg Cdr Atul Kumar Singh*
Classified Specialist (Ophthalmology), 12 Air Force Hospital,
Gorakhpur Uttar Pradesh, India

*Tel.: +91 09342020548
E-mail address: draksingh78@gmail.com

Received 27 June 2016
Accepted 27 June 2016

<http://dx.doi.org/10.1016/j.mjafi.2016.06.012>
0377-1237/

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Armed Forces Medical Services.

Reply

Dear Editor,

We thank the reader for the interest shown in our article. The queries raised by the reader are interesting and also very relevant to the Armed Forces where myopia is a common ground for rejections in recruitment as well as commissioning medical examinations. Our reply is as below:

Change in axial length was not evaluated as an outcome parameter in this study, since the follow up period for final outcome assessment was short (12 weeks). Orthokeratology is not known to affect axial length significantly over short periods of wearing. Axial growth of eyeball is usually complete by 19 to 20 years of age and all subjects in our study were between 19 to 29 years of age. Arrest of myopia by retardation of axial growth by orthokeratology may be possible in younger children and needs to be assessed over several years, as has been reported by some studies. The decrease in myopia in our study subjects fully correspond to the change in central keratometry and therefore not related to change in axial length. Decrease in quality of vision, glare, halos or decreased contrast sensitivity were not seen in any of the patients. On the contrary there was high level of satisfaction among the patients which probably explains the zero dropout rate in this study.

The final query by the author, as to whether it is possible to detect temporary suppression of myopia by candidates or recruits by use of orthokeratology, is extremely important in the Armed Forces context. As a matter of fact this article is based on an Armed Forces Medical Research Committee project which was designed to address this issue. Based on our study results we can say that the corneal changes induced by orthokeratology are not discernible on routine slit lamp examination. Corneal topography shows a typical pattern of central flattening and thinning. However these changes are not very different from those induced by other refractive procedures for myopia. We have suggested that certification for orthokeratology should be added to the existing certification for keratorefractive surgeries. In cases where the axial length is unusually long in relation to a near emmetropic refraction, orthokeratology treatment may be suspected. In such cases a corneal topography which shows a typical pattern of central flattening and thinning can substantiate the suspicion. This will however require axial length measurement in every case which is not the usual practice currently. Perilimbal hyperemia and upper tarsal conjunctival papillae should alert the

examiner to possible contact lens use but may not be seen in every case. Candidates in whom orthokeratology treatment is confirmed should be declared unfit in the first instance as assessment of actual myopia is not reliable in such a situation. They should be advised to discontinue orthokeratology at least for one month before reporting for appeal medical examination. Reversal of corneal topography changes must be ensured before declaring them fit in case the final myopia is assessed to be within acceptable limits. We once again thank the reader for raising these important issues.

Gp Capt M A Khan*
Associate Professor, Department Of Ophthalmology, Armed Forces
Medical College, Pune 411040, India

Maj Ashutosh Gupta
Resident, Department Of Ophthalmology, Armed Forces Medical
College, Pune 411040, India

Maj Gen T S Ahluwalia
Commandant, Command Hospital (Eastern Command), Kolkata,
India

Brig P S Moulick
Professor and Head, Department Of Ophthalmology, Armed Forces
Medical College, Pune 411040, India

Brig V S Gurunadh VSM
Commandant, Military Hospital, Wellington, Tamil Nadu, India

Lt Col Sandeep Gupta
Assistant Professor, Department Of Ophthalmology, Armed Forces
Medical College, Pune 411040, India

*Corresponding author
E-mail address: mansurophthal@gmail.com (M.A. Khan)

<http://dx.doi.org/10.1016/j.mjafi.2016.06.012>
0377-1237/

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Armed Forces Medical Services.