of Ringer’s lactate (RL) and a balanced salt solution (BSS) on the postoperative outcomes of phacoemulsification, by a randomized control trial, has added in vivo evidence about the superiority of BSS plus.[1]

But except for the first postoperative day, there was no significant difference between the use of two fluids for phacoemulsification. It would have been better if the authors had also showed the visual acuity results on the first postoperative day. We presume that there were no intraoperative complications. A difference of 25 μm of corneal swelling might have been “statistically” significant, but was it “clinically” significant in terms of suboptimal visual acuity? A one-week follow-up would also have helped. An Indian-made RL costs about Rs. 25 only (< $0.5) compared to Rs. 2800 ($62) for BSS plus. If we were to calculate a cost-benefit ratio, would a single-line visual acuity difference on the first postoperative day justify such an increased cost for most patients? Even Indian-made BSS are more than four times as costly as the RL. Also, the aqueous turnover time in the anterior chamber is less than 24 h. Hence the irrigating solution would not make any difference beyond the first few days.

BSS plus definitely would have incrementally helped in complicated cataracts, very hard cataracts, patients with poor endothelial cell counts, very old patients, and also where such high-viscosity devices were not available. The authors need to be congratulated for such less endothelial cell loss,[1] compared to other studies.[2,3] This might be due to the operating surgeon’s vast experience, selection of cataracts, and use of high-viscosity agents such as Provisc™ and Viscoat™.

In a country like ours, operating surgeons need to choose their consumables rationally, not just the best available, but rather optimally available.[4] It can be tailored for each cataract surgery. Ruit et al. had found no significant difference in corneal thickness and visual acuity, even on the first postoperative day, when comparing manual small incision cataract surgery and phacoemulsification.[3] A BSS is better, but it can only be called “statistically,” not “clinically” superior to the RL, unless we have evidence to the contrary.

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Dear Editor,

We read with great interest the article titled “Ocular toxicity of Calotropis procera (Sodom apple)” by Basak et al. [1] A prospective randomized clinical trial of phacoemulsification vs. manual sutureless small-incision extra capsular cataract surgery in Nepal. Am J Ophthalmol 2007;143:32-8.

3 and 4 in his letter are not published in peer review-indexed journals. That is why they were not included.

Unfortunately, there is no mention of these case reports/from India [2-4] and one from Saudi Arabia [5], which are mentioned in the references below.

During the course of our study, we performed an exhaustive search of the published literature for related studies. Besides this had prompted us to conduct a study on the same (presented as Poster no. 049 entitled “Spectrum Of Ocular Manifestations of Calotropis Induced Chemical Injury” in the 67th All India Ophthalmology Conference, 5-8 February, 2009, Jaipur).

In Bengal, the power vendors are predominantly male, and direct worshipping rites in the temple are performed by male Brahmin pundits, called purohits. In worshipping rites, Slit lamp examination showed dermatitis explaining for this could be that females are more involved in worshipping rituals. Most patients showed a dramatic response in terms of symptomatic comfort and best-corrected visual acuity.

We studied 47 patients reporting to the Ophthalmology Department between June 2005 and May 2008, all with a positive history of contact with Calotropis latex. In our study, females were more affected (70%) as against male 36% and keratouveitis in 9% of the cases. Secondary glaucoma was not seen in any patient. Therefore, there was no scope of mentioning this reference in our report.

We do not have an explanation as to why there was a missing links in our study, females were more affected in our study, whereas, male was not seen in any patient. Therefore, there was no scope of mentioning this reference in our report. We had submitted our manuscript in July 2007. All patients were treated with topical antibiotics, steroids, cycloplegics and lubricants. Most patients showed a dramatic response in terms of symptomatic comfort and best-corrected visual acuity.

To conclude, Calotropis-induced ocular injury is not of infrequent occurrence in the Indian scenario and may be associated with keratouveitis. Thus, it becomes imperative for ophthalmologists to entertain a high index of suspicion for this condition.

Authors' reply

The authors wish to thank Lakhtakia et al. [1] A probable explanation for this could be that females are more involved in worshiping rituals. As a result, we too get to see many cases of Calotropis-induced ocular injury.

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Secondary glaucoma in seven (24.1%) cases. We had just analyzed the reports retrospectively. As we routinely performed noncontact tonometry in all our patients. We do not have an explanation as to why there was a missing links in our study, females were more affected in our study, whereas, male was not seen in any patient. Therefore, there was no scope of mentioning this reference in our report. We had submitted our manuscript in July 2007. All patients were treated with topical antibiotics, steroids, cycloplegics and lubricants. Most patients showed a dramatic response in terms of symptomatic comfort and best-corrected visual acuity.

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