Reply: We thank Drs. Gupta and Ram for their interest in our paper and will address each of the issues they raised.

In response to their first question, 4 (6.8%) survey respondents did not choose an available option with regard to their preference when faced with inadequate capsule support but rather offered free-text responses indicating that their preference would depend on the clinical situation. Two of these respondents also mentioned using capsular tension rings or segments depending on intraoperative factors.

Drs. Gupta and Ram correctly observed a discrepancy between the text and Table 1 regarding the number of respondents who completed a fellowship. We confirm that the table is correct, accurately reflecting that 42 respondents completed fellowship.

With regard to questions raised about AC IOLs, although our survey did not capture whether respondents felt equally comfortable with both options (AC IOLs and scleral-fixated PC IOLs), all respondents who indicated they felt comfortable placing scleral-fixated PC IOLs independently also indicated comfort with AC IOL placement. As indicated in Table 3, 17 (47.2%) of these respondents favored primary AC IOL placement in the setting of inadequate capsule support. Although our survey did not inquire specifically about shorter surgical times as a reason for IOL preference, of the 17 respondents who indicated comfort with both IOL types and favored AC IOL placement, 8 (47.1%) indicated a decreased risk for intraoperative complications, 5 (29.4%) indicated avoidance of a second surgery, 2 (11.8%) did not select an available answer, 1 (0.1%) indicated decreased risk for long-term complications, and 1 (0.1%) indicated best visual outcome as their reason for choosing primary AC IOL placement.

Last, with regard to the third and fifth points raised by Drs. Gupta and Ram, we respectfully remind our readers that our study reports survey data rather than actual surgical outcomes. The hypothetical clinical scenarios posed in our survey were crafted to identify patient characteristics that surgeons might consider when determining their intraoperative approach to inadequate capsule support. Phacoemulsification versus extracapsular cataract extraction was not included in the clinical scenarios contained in our survey; however, we agree this distinction would be of interest for further study. Similarly, we believe that fixation technique, IOL type, and delay after primary surgery represent additional factors worthy of further study on this topic.

As indicated in our introduction, clinical outcome data regarding AC IOLs versus scleral-fixated PC IOLs have been mixed to date, without a strong consensus in the literature favoring the superiority of either IOL type. The results of our survey provide information regarding current practice patterns among cataract surgeons as well as the surgical training background and patient characteristics that influence these patterns.—Rebecca Sorenson, MD, Ingrid U. Scott, MD, MPH, Steven H. Tucker, BS, Vernon M. Chinchilli, PhD, George C. Papachristou, MD

Cystoid macular edema after femtosecond laser–assisted versus phacoemulsification cataract surgery

We read with interest the findings of Ewe et al.1 We respectively suggest that the results do not support the stated hypothesis and conclusions and might be interpreted in an alternative manner.

The study design was to evaluate the incidence of cystoid macular edema (CME) between the 2 groups, and the study found that there was no statistically significant difference. The authors performed a further subgroup analysis of femtosecond laser–assisted cataract surgery cases after a software upgrade and again found no statistical difference in the incidence of CME. These findings are consistent with previously published prospective studies that similarly described no difference in the incidence of clinical CME between femtosecond laser–assisted cataract surgery and manual surgery.2,3 Despite no statistical difference and that the smaller cohort effectively reduced the potential power of the results, the authors concluded that “CME might be a sub-threshold retinal injury safety signal.” No published study has indicated that the incidence of clinical CME is significantly higher after femtosecond laser–assisted cataract surgery, and one cannot therefore use these results to speculate about possible damage to the retina by all makes or any make of femtosecond laser.

The sentence stating “CME is now typically less common because of prophylactic pre- and postoperative topical NSAID [nonsteroidal antiinflammatory drug] use combined with postoperative topical steroids” can also be challenged. The reference used is from a 1996 study4 that evaluated angiographic CME in groups receiving diclofenac or a placebo. There are several concerns referencing this study; namely, the small sample and the corresponding high incidence of intraoperative complications. Of clinical