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Reply: I appreciate these helpful comments. (1) The label of the x-axis in Figure 1 has an error, as Dr. Shoaib pointed out. It should be “Years after trabeculectomy.” I apologize for our mistake. (2) The sentence about antimetabolic agent injections is in the “Surgical Technique, Phacoemulsification” section because these injections were not given at the time of phaco. We added this description because some surgeons give a shot of antimetabolic agent combined with phaco. (3) “All patients were treated with fluorometholone” is also in the “Surgical Technique, Phacoemulsification” section. We usually use this drug after phaco even in glaucomatous eyes. Perhaps there was room for misunderstanding because we did not include a statement that all patients were treated with betamethasone in the “Surgical Technique, Trabeculectomy” section. (4) The female: male ratio 117/61 in Table 1 is our mistake. The ratio should be 61:117. I apologize again for our mistake. However, the POAG:exfoliation glaucoma ratio is correct, and the identical number of female patients and POAG is a coincidence. It seems strange but is true. These ratios are similar to those in the previous report by Takihara et al., which was performed at the same institute as the current study. —Toshihiro Inoue

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Anterior capsulorhexis creation in modified capsular tension ring implantation

I would like to discuss some methods and findings observed in the study of modified capsular tension ring implantation by Buttanri et al. The retention of the capsular bag and in-the-bag intraocular lens (IOL) implantation with the use of endocapsular supporting devices in traumatic subluxated cataract is a challenging task. In the Buttanri et al. study, a cystotome was used to start an anterior capsulorhexis near the area of zonular dialysis and a Utrata forceps was used to complete a wide (5.5 mm or larger) central capsulorhexis. However, it would be preferable to start the anterior capsulorhexis away from the area of zonular dehiscence to minimize stress on the surrounding intact zonular fibers because the capsule can be inelastic and initiating a capsulorhexis can be difficult. Also, it would be easier to perform a relatively smaller capsulorhexis, especially in a larger subluxation, with the additional advantage that it will decrease the turbulence within the bag during phacoemulsification. The capsulorhexis can be enlarged later based on the optic size.

Buttanri et al. noted posterior capsule opacification (PCO) in 8 cases (50%) and attributed it to the fixation hook of a modified capsular tension ring (CTR). They should also indicate whether the PCO was limited to the quadrant where the fixation hook was sutured, the type of IOL material (hydrophilic/hydrophobic), and any case in which the capsulorhexis was off-center. The zonular dehiscence in the opposite quadrant that was assumed to be caused during fixation of the modified CTR might have resulted from the use of the iris hooks.

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Reply: Although starting the capsulorhexis from the area of zonular dehiscence is not mandatory, it has some advantages in surgical manipulations. If the capsulorhexis is started near the area of intact zonules, it is difficult to control the tear in the area of zonular dehiscence because the capsule is more unstable and inelastic in this area. Subluxated lenses may decenter toward the intact zonular zone. The area near the intact zonular fibers may be under the iris and starting a capsulorhexis under the iris may be difficult. After starting the capsulotomy in the area of zonular dehiscence, we use iris hooks to hang the capsulorhexis edges to centralize and stabilize the lens and continue the capsulorhexis. We suggest...