Re: Scleral fixation of one piece intraocular lens by injector implantation

Dear Editor,

We agree with the concern that we did not mention the increasingly popular techniques of secondary intraocular lens (IOL) implantation in aphakia management, namely intrascleral sutureless haptic fixation and iris-claw lenses and it would be better to concern about those techniques in the article. However, we believe that intrascleral sutureless haptic fixation techniques are so cumbersome that no one, but a veteran ophthalmic surgeon can succeed it and they are not as popular as the reviewer suppose. This can be more understood after trying a few attempts. Today, scleral fixation of a foldable IOL seems to be the most popular method for aphakia in the world.

In our case series, we used one-piece IOLs, and it is true that transscleral IOL fixation has some risks and complications such as IOL decentration, tilt, suture breakage, vitreous hemorrhage, and endophthalmitis. Except IOL decentration and tilt, our procedure has the same risk factors that can be seen in all sutured sclera fixated IOL surgeries, and these are the limitation of our procedure. It would be better to prefer a three-piece hydrophobic IOL to decrease the likelihood of such complications.

In a scleral-fixated IOL, the haptics are stacked in the ciliary sulcus, and the IOL is not suspended. Hence, we do not agree with the concern that there is more pseudophacodonesis, and this may lead to posterior segment complications in the long-term.

Late suture breakage and other complications of scleral fixated posterior chamber IOLs are possible to occur, but they were reported in the literature as case reports. Their very low ratio is not an obstacle to do this method. The likelihood of having a complication in a normal phacoemulsification surgery is much more and this situation is not an obstacle to perform phacoemulsification surgery.

We left suture knots were long, extended and buried under the conjunctiva in order to prevent suture exposure and external suture erosion. We did not leave the sutures short in length. It is the choice of the surgeon to make a scleral flap, scleral pocket or patch graft to cover the external suture.[1]

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Reference
1. Can E, Basaran R, Gul A, Birinci H. Scleral fixation of one piece...
Sterile endophthalmitis following intravitreal triamcinolone acetonide

Dear Editor,

Sterile endophthalmitis is defined as true intraocular inflammation following intravitreal injection of triamcinolone acetonide (IVTA) that cannot be attributed to an infectious process.

We report three cases of sterile endophthalmitis that occurred in July 2010.

A 49-year-old male patient was treated with IVTA for diabetic macular edema (DME) in his left eye. Two days after the injection, the patient complained of ocular discomfort. His vision was 20/400, which was the same as before IVTA. Slit lamp examination showed 1 mm hypopyon in the anterior chamber. B-scan showed vitreous opacities [Fig. 1]. The vitreous culture was performed, followed by intravitreal injection of vancomycin and ceftazidime. The result of vitreous culture was negative. Furthermore, he was treated with oral moxifloxacin and topical prednisolone acetate and moxifloxacin. At 2 weeks after IVTA, the anterior chamber became clear and the hypopyon resolved completely, but the diffuse vitreous haze remained. At 2 months follow-up, visual acuity (VA) had improved to 20/100.

A 57-year-old male patient was treated with IVTA for panuveitis in his left eye. At the first visit on day 1 after IVTA, corneal edema, a severe anterior chamber reaction with hypopyon, and conjunctival hyperemia were detected in the left eye. His VA had decreased from 20/200 to 20/400, but the patient denied having ocular pain. Because of the vitreous inflammation, he was treated with oral moxifloxacin and topical prednisolone acetate, and moxifloxacin, but no vitreous sample was obtained. The inflammation was completely resolved in 2 weeks with the improvement of VA to 20/100.

A 59-year-old male patient was seen for a scheduled examination 1-day after IVTA in the right eye for treatment of DME. His VA dropped from 20/200 to counting fingers. He denied having any pain. He had a 1 mm area of hypopyon with flare. Fundus examination revealed vitreous opacities. Vitreous culture was promptly performed, followed by intravitreal injection of vancomycin and ceftazidime. In addition, oral moxifloxacin and topical prednisolone acetate, and moxifloxacin were started. The results of the vitreous culture were negative. Hypopyon resolved in 3 days, and after the 1st week, the anterior chamber and vitreous reaction had cleared.

Intravitreal injection of triamcinolone acetonide was performed in 10 eyes in July 2010, and sterile endophthalmitis

Table 1: Characteristics of patients with sterile endophthalmitis

| Case number | Age (years) | Indication for IVTA | Phakic status | Time to presentation (day) | Culture results | Other past ocular history | Recovery to initial VA |
|-------------|-------------|---------------------|---------------|---------------------------|----------------|--------------------------|-----------------------|
| 1           | 49          | DME                 | Phakic        | 2                         | Negative       | Vitrectomy               | Yes                   |
| 2           | 57          | Panuveitis           | Phakic        | 1 ‑ Repeated IVTA          | Yes            |                         |                       |
| 3           | 59          | DME                 | Pseudophakic  | 1                         | Negative       | Cataract surgery         | Yes                   |

IVTA: Intravitreal injection of triamcinolone acetonide, VA: Visual acuity, DME: Diabetic macular edema.