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Sir,
Surgical management of iris defects with prosthetic iris devices

We read with interest the article by Mavrikakis *et al* (*Eye* 2005; **19**: 205–209) on the surgical management of iris defects with prosthetic iris devices. In this case series, the authors presented nine patients with iris defects managed by prosthetic iris device with excellent results. While we share the same experience with the authors that large iris defect like those with more than 90° are most effectively managed by prosthetic device. Small iris defect (less than 90°) may benefit from pupilloplasty. After pupilloplasty, the pupil may be slightly displaced but this can be managed by selective sphincterotomy at the opposite iris margin to achieve a well-centred pupil.

Sphincterotomy can be achieved by cutting the iris margin with vennis scissors or simply stretching the iris margin with iris retractors. While this approach may be associated with slightly more early postoperative inflammation due to iris manipulation, the inflammation typically settles in the first week. This method particularly useful in patients without an intact capsule in which iris prosthesis cannot be placed. This technique can also avoid migration the iris prosthesis as the capsular bag contracts.

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Sir,
Reply: Surgical management of iris defects with prosthetic iris devices

We thank Drs Cheng, Yuen, Rao, and Lam for their comments on alternative surgical procedures for correction of small iris defects (less than 90°). We agree that pupilloplasty using a McCannel suture is an established technique for correction of small iris defects, but it is not without shortcomings. As they very correctly mentioned in their letter, pupilloplasty may be associated with early postoperative inflammation and an ectopic pupil. Although the postoperative inflammation could be settled with intensive use of topical steroid, the ectopic pupil needs to be corrected, as they pointed out, with multiple selective sphincterotomy. This has disadvantages such as hyphaema, uveitis, photophobia, and loss of iris tone. Thus, it is our departmental policy not to perform such sphincterotomy. Secondly, pupilloplasty may leave a gap at the iris root resulting in glare or monocular diplopia. Thirdly, while we agree that pupilloplasty may be useful in patients without an intact capsule, in our series all cases with small iris defects had an intact capsule and therefore received an artificial iris device (Morcher coloboma diaphragm Type 96G). Finally, the issue of decentration of the artificial iris due to capsular bag contracture has been addressed within the context of the article by the use of a capsular tension ring.

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