



Figure 3 The posterior hyaloids face is removed facilitated by a raised bottle height and confirmed by triamcinolone 'staining'.

cannula and close it with a plug. Routine phacoemulsification is then completed and the corneal incision sutured. As the superior ports are not in place, there is no interference with access of instruments and incision placement for phacoemulsification (Figure 1). After phacoemulsification the infusion line is inserted and turned on. This firms up the eye, allowing easy insertion of the other two cannulae.

The fragility of 25 g instruments poses another problem, especially when trying to deal with peripheral pathologies, such as tears close to the ora serrata. This is effectively managed by the use of indentation to bring the peripheral retina to the ocutome, rather than tilting the eye to access peripheral pathology (Figure 2). The use of an effective wide-angle light such as the Photon (Synergetics Inc., MO, USA), allows one to plug this into one of the superior ports freeing one hand to indent. True bimanual surgery is thus facilitated allowing access to all areas of retina even in phakic eyes.

Induction of a PVD is more difficult, but raising the bottle to 100 cm momentarily greatly helps (Figure 3).

With an appropriate technique, TSV can deal with the vast majority of vitrectomy procedures, benefitting both the patient and the surgeon.

References

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Sir,

25-gauge vitrectomy: the hidden costs

We would like to congratulate P O'Reilly and S Beatty on reporting their initial experiences with 25-gauge transconjunctival sutureless vitrectomy. It is behoven on us as surgeons to clearly demonstrate an advance in patient's experience or improvement in postoperative outcomes before introducing surgical innovations to our routine practise. This article adds to the evidence we require to make this judgement in the case of 25-gauge vitrectomy.

Given that the authors observed postoperative hypotony in 25.6% cases ($n = 10$) and postoperative haemorrhage in 10.3% cases (posterior segment haemorrhage and hyphaema), we cannot agree with their conclusion that 'TSV 25M vitrectomy is a safe and effective procedure'. In addition, this paper does not present sufficient evidence to support a further claim that 'transconjunctival sutureless vitrectomy does not compromise the surgical or visual outcome of internal posterior segment surgery'.

A retrospective study of this nature is likely to reflect a selection bias towards the inclusion of uncomplicated cases suitable for training a surgeon in a new technique. Despite this, postoperative hypotony was common necessitating daily review of the patient. Any possible gains in comfort or decreased surgical time are thus outweighed by the very real inconvenience and cost of daily review for both patients and staff.

Further clarification on the cause of postoperative haemorrhage in this study is also required. We note that the presenting complaint was vitreous haemorrhage in ten cases and it would be important to know whether postoperative haemorrhage occurred exclusively in this group.

Finally, the authors alluded to the possible risk of endophthalmitis following postoperative hypotony. Concerns about an increased rate of endophthalmitis following 25-gauge vitrectomy have already been raised in the literature.^{1–3} This study presents the results from 39 eyes and larger numbers would be required to determine if the risk of endophthalmitis is increased, and therefore whether this technique really is as safe as the authors' claim.

In conclusion, we would caution surgeons to examine the evidence carefully before replacing current practise with a technique that has yet to demonstrate a real improvement in long-term patient outcomes.

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