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Sir,
Responding letter

We thank Drs Atan, Foy and Scanlon for their interest in our study. Our work was retrospectively done on digital image bank photographs for which we wish to define the effect of compression on detection and not the effect of initial image size on detection. In spite of this our conclusion still shows first, that 1.26 MB to 118 KB compression (1:11) remains adequate (which is in accord with the English National Screening Committee's recommendation upon compression ratios), and second that larger image sizes than those we used must be tested clinically. We also think that 'bigger is better' concerning retinal images.

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Sir,
Capsular folds should be documented in setting of small capsulorhexis

We read with interest the recent case report of Late-onset capsular block syndrome without lens displacement.¹ We note that the authors state the operation was uneventful with continuous curvilinear capsulorhexis of moderate size. However, they acknowledge that late structural

changes in the anterior capsule with rigid fibrosis had prevented IOL displacement and subsequent myopic shift in their case. It is our understanding that small capsulorhexis is a major risk factor for capsular block syndrome in the setting of retained viscosurgical devices based on fluid analysis.²

Our experience in a teaching hospital environment suggests that trainee ophthalmologists start operating by creating relatively small capsulorhexis. This is probably due to a lack of confidence and fear of running out into the zonules. Anatomical apposition of the intraocular implant to the iris in this setting can act as a mechanical block to aqueous outflow, leading to capsular distension syndrome.³

Comment

We wish to draw attention to the presence of posterior capsule folds following removal of viscoelastic after intraocular lens implantation in cataract surgery. These two stress lines are folds in the posterior capsule that are closely adherent to the back of the intraocular lens and span the equator between the locations of the two haptics. They can be made to rotate as the intraocular lens changes position during aspiration of viscoelastic. They are often visible at post-operative review. While some reports have queried their relevance, we suggest that their presence implies that the viscoelastic has been adequately removed following lens implantation.^{4,5} This positive sign should act as a training point for the trainee ophthalmologist and should be actively acknowledged. This should aid in preventing iatrogenic causes of capsular distension syndrome.

It is our belief that surgical notes should state positive presence of posterior capsule folds following removal of viscosurgical devices in the setting of small capsulorhexis.

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