

Sir,
Pseudophakic anterior chamber depth measurement

Nanavaty *et al*'s¹ hypothesis that a greater amount of post-phacoemulsification anterior capsule/intraocular lens overlap results in a greater amount of pseudophakic accommodation is intriguing and argued persuasively. However, despite their claims, to the contrary, IOLMaster (Carl Zeiss Meditec) measurements of anterior chamber depth (ACD), based on a slit lamp photographic technique, are generally considered unreliable in pseudophakic eyes^{2,3} and we believe that this may confound their conclusions. As described, immersion ultrasound and partial coherence interferometry are the golden standards for pseudophakic ACD measurement.

References

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NE Knox Cartwright¹ and DM Tole²

¹Department of Ophthalmology, Royal United Hospital, Bath, UK

²Department of Ophthalmology, Bristol Eye Hospital, Bristol, UK

E-mail: n.knoxcartwright@gmail.com

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Sir,
Reply: Pseudophakic anterior chamber depth measurement

We thank Knox Cartwright and Tole for reiterating our discussion on the methodology involved in this study. As discussed in the paper, Zeiss AC Master (based on the principle of partial coherence interferometry) could have been a better alternative.¹ Zeiss AC Master is no longer available commercially and so slit-lamp assessment of anterior chamber depth remains one of the methods that can be used if anterior segment OCT² or ultrasound biomicroscopy³ is not within practical reach. Moreover, the technique of anterior chamber depth measurement with IOL Master has already been reported to have a good reproducibility.⁴ The authors had subjected all the patients to the standard technique so that any bias (if present) may be nullified and the validity of the results are not affected.

References

- 1 Nanavaty MA, Raj SM, Vasavada VA, Vasavada AR. Anterior capsule cover and axial movement of intraocular lens. *Eye* 2008; **22**(8): 1015–1023.
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MA Nanavaty, SM Raj, VA Vasavada, VA Vasavada and AR Vasavada

Iladevi Cataract & IOL Research Centre,
 Raghudeep Eye Clinic, Memnagar, Ahmedabad,
 Gujarat, India
 E-mail: icirc@abhayvasavada.com

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Sir,
The use of Medpor-coated tear drainage tube in conjunctivodacryocystorhinostomy

Fan *et al*'s paper¹ on the use of Medpor-coated tear drainage tubes raises some important points regarding conjunctivodacryocystorhinostomy surgery. Jones in his original paper² describes how the tubes allow an epithelial-lined channel to form, connecting the conjunctiva to the nasal mucosa, and in effect keeping the tube outside the body. Porous polyethylene coating of the tube may allow fibrovascular ingrowth, but it simultaneously prevents a continuous epithelium forming, and therefore violates the basic surgical principle of implantable material being beneath a continuous epithelium to prevent infection. The high rates of conjunctival and nasal mucosal overgrowth found with these tubes, largely pyogenic granuloma formation, are the anticipated response to persistent inflammation and low-grade infection. The situation is analogous to pegging of porous orbital implants to increase prosthesis motility, rarely performed now due to the risk of infection and implant extrusion.

Jones² in the same study went further in suggesting that with time many patients would be able to dispense with their tube altogether. In practice, this is rarely the case, and most surgeons aim to retain the tube long term. As described by Rose and Welham,³ in what is probably the largest series (326 eyes) and longest follow-up (up to 23 years) of conventional Jones tube placements, problems with the tubes are common. At the mean time from tube placement of 1.3 years in Fan *et al*'s¹ paper, the