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Sir,

### Cystoid macular oedema after selective laser trabeculoplasty

We report a case of cystoid macular oedema (CMO) after selective laser trabeculoplasty (SLT). An 89-year-old Caucasian woman with a previous complicated left cataract surgery was referred to our practice. Visual acuity was 6/12 in the right eye and 6/36 in the left eye. There was right cataract, a left posterior chamber intraocular lens with an absent posterior capsule, and left CMO (later confirmed on optical coherence tomography (OCT)).

She underwent right cataract surgery, while the left eye was treated with topical dexamethasone 0.1% q.i.d. and ketorolac q.i.d. Over 2 years, acuity in the left eye improved to 6/9; however, intraocular pressure (IOP) increased to 30 mmHg. The topical steroid was ceased and topical brinzolamide (0.1% b.i.d.) commenced. On account of persisting elevated IOP and questionable compliance with brinzolamide, SLT was offered. Pre-laser acuity was 6/9 and IOP was 20 mmHg on brinzolamide. A 180-degree inferior treatment was performed with 57 applications of 0.7 mJ and total energy of 40 mJ. There was no post-treatment uveitis.

The patient noticed decreasing vision and at 4 weeks acuity was reduced to 6/18. The IOP had improved to 10 mmHg. Clinically, there was CMO, confirmed on OCT. Ketorolac drops q.i.d. were commenced and brinzolamide continued. Three weeks later acuity had improved to 6/6 with marked resolution of the macula both clinically and on OCT. The IOP remained at 12 mmHg.

To our knowledge, this is the first reported case of CMO after SLT, which is considered a relatively safe and

innocuous procedure.<sup>1–3</sup> As inflammatory processes may be inherent to its mechanism of action,<sup>3</sup> we postulate that upregulation of inflammatory pathways could have triggered a recurrence of the CMO, especially with an absent posterior capsule, allowing greater access of inflammatory mediators to the posterior segment. Other inflammatory reactions to SLT are well recognised, such as ciliary injection and anterior chamber inflammation,<sup>1,2</sup> and there is one report of choroidal effusion associated with severe inflammation.<sup>4</sup>

We recommend caution in using SLT in eyes with a tendency for developing CMO, especially if CMO has been prolonged or was associated with complicated cataract surgery. If SLT is required in such cases, one might consider pre-treating with a non-steroidal anti-inflammatory agent.

### Conflict of interest

The authors declare no conflict of interest.

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Sir,

### Simultaneous bilateral cataract surgery: a further advantage

We welcome the article by Nassiri *et al.*<sup>1</sup> Their paper lends further evidence to the growing body in support of simultaneous bilateral cataract surgery (SBCS).

As Nassiri *et al.* suggest, the main cited objection to SBCS is the very rarely reported (four cases in the literature) risk of bilateral simultaneous infectious endophthalmitis. Conversely, the advantages of SBCS have been repeated numerous times. We hypothesise a further advantage.

If we assume that a patient undergoing SBCS would have a clinic appointment, a biometry and assessment

appointment, surgery, and finally a post-operative visit, these patients would have had four appointments in total. Those undergoing conventional sequential surgery would have the same, followed by their second surgery and a final post-operative visit, totalling six visits. It has been suggested that the average round trip per hospital appointment is 56 miles.<sup>2</sup> This would lead to a total of 224 miles per SBCS patient (or 112 000 000 miles for 500 000 patients) and 336 miles per non-SBCS patient (168 000 000 miles for 500 000 patients). It is also suggested that there are 1.48 road fatalities per 100 000 000 miles of road travelled.<sup>3</sup> This would lead to a total of 1.66 deaths on the roads per 500 000 patients undergoing SBCS compared with 2.49 deaths for the same number of patients undergoing conventional monocular surgery. This would increase to 2.9 deaths if patients have a second assessment between surgery (thereby totalling seven trips). There is, therefore, potentially 1.5–2 times the risk from death in a road traffic accident by undergoing extra visits for unilateral sequential cataract surgery in those suitable for SBCS. The patients in Nassiri's cohort who cited 'difficulty in travelling' as a reason for choosing SBCS may well have been very astute indeed.

In conclusion, the advantages of SBCS are numerous and well documented. The risks and disadvantages are few and sparsely reported. We would recommend that SBCS be considered more frequently for those patients who are suitable.

We challenge your readership with the following question: Which is worse—one case of bilateral simultaneous endophthalmitis or a dead patient from the extra visits for sequential surgery?

#### Conflict of interest

The authors declare no conflict of interest.

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#### Sir, Heavy internal tamponades and risk of hypotony

The recent publication by Li *et al* (*Eye*, E-pub 27 March 2009) on the complications associated with the use of Densiron 68 and other heavy internal tamponades necessitates a comment regarding the risk of hypotony. The authors summarize that, with the exception of our previous publication on perfluorohexyloctane (F6H8),<sup>1</sup> 'there is no indication for an increased risk of postoperative hypotony with heavy endotamponades'. This statement is misleading. With regard to F6H8, there are, in addition to our report, serious indications for an increased risk of hypotony.<sup>2–4</sup> Altogether, these authors observed hypotony in 6 of 26 eyes (23%). In our series,<sup>1</sup> which is the one with the longest follow-up so far, it was evident that hypotonia developed progressively after the removal of F6H8 and was manifest in the majority of cases at the final 6-months examination. A progressive trend towards low mean intraocular pressure was also observed in the multicentre approval study on F6H8,<sup>5</sup> which unfortunately covered only a postoperative period of 3 months.

#### Conflict of interest

The author declares no conflict of interest.

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