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JM Monés, L Amselem, A Serrano, M Garcia and M Hijano

Institut de la Màcula i de la Retina, Centro Médico Teknon, Barcelona, Spain
E-mail: jmones@institutmacularetina.com

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Sir,

The effects of phacoemulsification on intraocular pressure and the ultrasound biomicroscopic image of filtering bleb in eyes with cataract and functioning filtering blebs: comparison of the Tongren Eye Center and Peking University Eye Center data

Wang *et al*¹ should be commended for their effort to investigate the effects of phacoemulsification on the intraocular pressure (IOP) and ultrasound biomicroscopic image of filtering bleb in eyes with cataract and functioning filtering blebs. UBM is a good method used worldwide to observe the internal structure of filtering blebs.² IOP is important for evaluating the filtering function of the eyes with filtering blebs. However, Wang *et al* claim that, unlike our results,³ the IOP increased after phacoemulsification at each follow-up visit.

In the discussion, Wang *et al* compared their results with the studies of Klink *et al*⁴ and Rebolleda *et al*.⁵ In all, 70.4% of the patients in Wang's study were those with angle closure glaucoma compared with no patient in Klink's study and only 6 of the 49 patients in Rebolleda's study. Comparison of different types of glaucoma may make their study underpowered and of limited value.

We noticed in Wang's study that the IOP before phacoemulsification ranged from 4.0 to 19.7 mm Hg. No patient required glaucoma medication. A 4 mm Hg IOP without antiglaucoma medicine was too low for most glaucoma patients. We wonder whether such patients have complications such as choroidal detachment, chronic hypotony or overfiltering bleb. Choroidal detachment may have its own natural evolutionary course, and hence after choroidal reattachment the IOP may increase. Phacoemulsification has been used to treat overfiltering blebs⁶ and chronic hypotony,⁷ and hence the IOP increase after phacoemulsification was not difficult to understand.

Visibility of the route under the scleral flap and reflectivity inside the bleb are two important aspects that can be help evaluate the UBM image of a filtering bleb. The authors claim that eyes with an invisible route under the scleral flap and stronger intrableb reflectivity in UBM image before phacoemulsification had greater postoperative antiglaucoma failure.

We believe that the status before phacoemulsification is indeed important, but the change occurring after phacoemulsification might be even more important because it may reflect the effect of the surgery. Our study

showed that the increase in reflectivity inside the bleb after phacoemulsification might be a risk factor of IOP control failure.³ Unlike our study, Wang *et al* claim that the visible route under the scleral flap became invisible or narrower, and the low reflectivity inside the bleb increased in most eyes, but the changes before and after phacoemulsification did not have statistical significance. It would be of particular interest if the authors could do a further subgroup analysis to analyse why this happened.

Conflict of interest

The authors declare no conflict of interest.

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Y Hong, C Zhang and W Wang

Peking University Eye Center, Peking University Third Hospital, Beijing, China
E-mail: hongshadow@gmail.com

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Sir,

The reuse of ophthalmic minims: an unacceptable cross-infection risk?

We read with interest the article on 'The reuse of ophthalmic minims: an unacceptable cross-infection risk?' In the clinical study, the authors found that multiple applications of unpreserved proxymethacaine 0.5% and fluorescein 0.25% in a Minims vial intended for single application have the potential to transmit bacterial infection. In all, 17% of 41 samples grew normal flora from the conjunctiva and lid area, which are mainly coagulase-negative Staphylococci and *Corynebacterium* spp.¹

The authors highlighted the rationale of application of single-use Minims per patient, but cited the cost that this