visual acuity. None of our patients needed more than a short course of steroid drops. Although we do not know which other factors are causing the development of depigmentation of the iris, in none of our patients a concave iris has been the primary factor. Gonioscopy did not reveal pigmentation of the chambre angle. In addition, in pigment glaucoma the pattern of translucency of the iris differs from the pattern seen here, which is similar to the pattern in our patients. In any patient with iris translucency it is wise to evaluate the concavity of the iris by gonioscopy, but it is also possible that in this patient the subconjunctival steroid injection is one of the factors for developing glaucoma.

Conflict of interest
The author declares no conflict of interest.

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Sir,
Intravitreal ranibizumab for choroidal neovascularisation secondary to pathologic myopia: 12 month results

We read with interest the article 'Intravitreal ranibizumab for choroidal neovascularisation secondary to pathologic myopia: 12 month results'. We noted that the study group was very diverse with regard to age and incorporated people with myopia ranging from −5 to −18 D. We would like further clarification whether Monés *et al*[1] used refraction as the only assessment of myopia. We believe that some of the more elderly patients may have had a myopic shift related to lenticular changes. The axial length would have given further support to determine the true pathological myopia, and we are interested to know whether this was measured. The number of injections of ranibizumab is very low compared with that often reported for age-related macular degeneration and choroidal neovascularisation. For example, a recent study[2] on the frequency of injections needed stated 5.2 as the mean number of injections *vs* 1.52 in this article. Of interest is the finding by Ruiz-Moreno *et al*[3] that three monthly injections was an appropriate regimen to manage choroidal neovascularisation, as disease activity in pathological myopia is sometimes difficult to predict in-between injections.

Conflict of interest
The authors declare no conflict of interest

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Sir,
Reply to Rajendram *et al*

We deeply appreciate the comments from Rajendram *et al*[1] regarding our article 'Intravitreal ranibizumab for choroidal neovascularisation secondary to pathologic myopia: 12 month results'.[2] We agree that myopia cannot be assessed accurately only with refraction. In some patients lenticular changes could contribute to a certain amount of myopia. Axial length was not used in this study. However, patients had to have retinal abnormalities consistent with pathological myopia (such as lacquer cracks, peripapillary atrophy, etc).

Regarding the frequency of injections, the main characteristic of myopic choroidal neovascularization in comparison with age-related macular degeneration is the very different dynamics of CNV progression. Myopic CNV is more likely to respond with less injections needed and with improvement in vision. As reported in this study, the loading phase does not seem to be necessary and could represent an overtreatment for many patients. The recurrence is unpredictable; some patients may never have it, while many patients may not have it for several months. This justifies the pro renata regimen. Owing to the potential specific risk of myopic eyes, it seems advisable to reduce the number of injections as possible. We once again thank Rajendram *et al* for their interest and comments.

Conflict of interest
The authors declare no conflict of interest

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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 blebs[6] 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 antiglacuoma 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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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