

Table 1 Comparing shield and shield-less cohorts

	Shieldless		Shield		P-value
Mean age (years)	72.8	± 7.7	73.4	± 7.2	
Total patients	425	30.2%	982	69.8%	
Scleral tunnel	298	70.1%	668	68.0%	
Clear corneal	127	29.9%	314	32.0%	
Uveitis	6	1.4%	19	1.9%	0.661
Corneal oedema	5	1.2%	9	0.9%	0.770
IOP >21 mm Hg	5	1.2%	8	0.8%	0.548
Iris prolapse	1	0.2%	1	0.1%	0.513
Endophthalmitis	0	0.0%	1	0.1%	1.000
Macular oedema	3	0.7%	15	1.5%	0.302

Abbreviation: IOP, intraocular pressure.

(*n* = 1407). One surgeon used no shields throughout this period (regardless of patient factors; *n* = 425). All other cases (*n* = 982) wore a Cartella shield overnight for three weeks. Both groups contained similar demographics and wound construction (Table 1). The shield-less regime conferred no safety disadvantage. All adverse events had nonsignificant *P*-values with Fisher's exact test (Table 1).

A total of 46 patients responded by anonymous questionnaire; 59% stating shields were 'uncomfortable' and 43% would have 'preferred to not wear' one. Comments included 'If it helps I will wear it' and 'I assume I was given it for a reason'. With the recent advances in wound construction, surgical outcomes and complication rates is the routine use of shields without evidence still necessary in 2011?

Conflict of interest

The authors declare no conflict of interest.

References

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Sir,
Response to: Idiopathic uveal effusion syndrome causing unilateral acute angle closure in a pseudophakic patient

We read with interest the case report of presumed idiopathic uveal effusion syndrome (IUES) associated

with unilateral acute angle closure (AAC) in a pseudophakic patient.¹

The authors propose that the case occurred in the absence of pupil block, however, the anterior segment OCT image presented shows iris convexity implying pupil block. We note that no posterior synechiae were seen clinically, however, the B-scan ultrasound images suggest adhesions between the posterior iris and the anterior capsule, consistent with seclusio pupillae. Pseudophakic pupil block with synechiae not visible at the pupillary margin can occur.² Furthermore, the case resolved with pupil dilation and medical intraocular pressure control supporting a pseudophakic pupil block mechanism.

The association of uveal effusion with AAC is well recognized and has been reported to occur in up to 58% cases of acute primary angle closure.³ As stated by the authors, IUES is a diagnosis of exclusion; and is typically associated with serous retinal detachment.⁴ No serous retinal detachment is seen in the case presented.

Their case is certainly unusual with respect to the fact that AAC occurred with an IOL placed in the capsular bag with presumed correct orientation. We would suggest the authors consider prophylactic peripheral laser iridotomy in their case to reduce the risk of a repeat AAC episode.

Conflict of interest

The authors declare no conflict of interest.

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Sir,
Response to Day and Foster

We value the interest Day and Foster¹ have expressed in our case.² The reported cases of seclusio pupillae in