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**Sir,
Stability and safety of MA50 intraocular lens placed in the sulcus**

We are grateful to the authors¹ for making this useful contribution to a limited literature, alluding to the fact that an ideal sulcus intraocular lens (IOL) option remains elusive, across a wide refractive range, for cases where posterior lens capsule support is lost.

Of particular interest is the data relating to the prevalence and description of glaucoma in this cohort, with none of the patients in whom optic capture was achieved developing glaucoma. The inference is that of the 38 eyes that did not have optic capture, 9 of these (24%) developed either ocular hypertension alone, glaucoma, or UGH type syndrome (non-neovascular glaucoma cases). It does seem reasonable here to suggest that the risk of further morbidity in these patients is enhanced by the absence of a captured optic, where support was available, exposing them to a greater risk of developing secondary glaucoma.

We do believe that the mechanism of ocular hypertension/glaucoma in this context is primarily an outflow obstruction, stemming from pigment deposition at the trabecular meshwork. This clinical scenario is well described in the literature for both sulcus-placed single-piece acrylic and 3-piece acrylic-PMMA intraocular lenses.^{2–4} Indeed, from our own experience, the sequelae here can be significant, requiring aqueous shunt surgery.

In this patient cohort, most notably those without optic capture in whom the IOL would be prone to lateral instability, which included those cases in which ocular hypertension/glaucoma was observed, were no unilateral angle morphology changes observed at the trabecular meshwork consistent with pigment dispersion? One

assumes that the clinical phenotyping of these patients was comprehensive, including gonioscopic evaluation? With a relatively short median long-term follow-up period in this study, more cases of pigment dispersion glaucoma may emerge after a longer follow-up period, as demonstrated in other case series.³ It may be appropriate to counsel patients of this risk.

We believe that the importance of optic capture is understated and ought to attract greater emphasis in the management of phacoemulsification complications. Indeed, this practice was a recommendation of the 2009 ASCRS Cataract Clinical Committee, with Chang *et al*² eloquently describing the technique and the mechanisms of advantage.

Conflict of interest

The authors declare no conflict of interest.

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**Sir,
Response to Dr Sandhu and Dr Clarke**

We thank Dr Sandhu and Dr Clarke for their correspondence in regard to our paper on the safety and stability of the MA50 intraocular lens when placed in the sulcus.¹

In addressing the angle morphology of patients without optic capture of the intraocular lens in which ocular hypertension, glaucoma or iritis was observed, none were diagnosed with pigment dispersion syndrome based on clinical characteristics. Of the eight patients, three had iritis, one had iritis and open angle glaucoma, one had ocular hypertension alone, one had steroid-induced ocular hypertension, one had neovascular