Sir,
Response to: 'Unmet needs of cataract blind children in special schools in Southeast Nigeria'

We thank Aghaji *et al*[1] for their interest in our article.[2] We would like to point out, however, that this letter is discussing an entirely separate issue, namely, the need to improve the access to care for children with cataract worldwide, especially in underprivileged areas. Our paper is a quality assurance study driven by factors imposed in a developed country in which patients and payers expect to see quality outcome reports that may be reflective of the surgical and institutional quality of service. In this study, we utilized exclusion criteria that would eliminate confounding factors that might impact visual acuity outcomes. One example is the exclusion of children with congenital cataract who had significant delays in presentation, since the visual outcomes would not be reflective of the surgical care provided, but, rather, the result of irreversible deprivation amblyopia. By eliminating as many confounding factors as possible, it allowed us to examine outcomes that are more directly influenced by quality of care. Our study is like adult benchmark papers that report only on populations with 'uncomplicated' acquired cataract. In contrast, the patients that are reported in the letter represent children who would be expected to have poor visual outcome by common standards, because of the late presentation, even though quality of the surgical care was good. As the authors point out, the outcomes are biased because the study population consists of children with cataract who were enrolled in a school for the blind. There is no information in the letter about quality of surgical care or quality assurance in general. The population and outcomes are similar to those reported by Ganesh *et al*.[3]

While we appreciate and support the thoughts in this correspondence, it must be clear that the purpose of our paper, which reports quality assurance results with timely intervention and modern techniques, is different from the outcomes that might be found for children with more complex conditions or delayed interventions. Surgery for these children may still provide improved visual function, but the final vision is understandably less good than in our study, and the issue is not the quality of care at the time of surgery. The issue is need for improved surveillance and timely intervention in underserved areas. We support increased awareness of the need for better global pediatric eye care particularly with regard to diagnoses outlined in the WHO 2020 bulletin, which includes treatment of children with early childhood cataract.[4]

Conflict of interest

The authors declare no conflict of interest.

References

1 Aghaji A, Okoye O, Bowman R. Unmet needs of cataract blind children in special schools in Southeast Nigeria. *Eye* 2017; epub ahead of print; 10.1038/eye.2017.176.
2 Nihalani BR, VanderVeen DK. Benchmark for outcome indicators in pediatric cataract surgery. *Eye* 2017; **31**: 417–421.
3 Ganesh S, Arora P, Sethi S, Gandhi T, Kalia A, Chatterjee G *et al*. Results of late surgical intervention in children with early-onset bilateral cataracts. *Br J Ophthalmol* 2014; **98**: 1424–1428.
4 Gilbert C, Foster A. Childhood blindness in the context of VISION 2020–the right to sight. *Bull World Health Organ* 2001; **79**: 227–232.

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Sir,
Risk of intraocular hemorrhage with oral anticoagulants in ocular surgery

We believe that the review by Talany *et al*[1] needs further discussion. The authors wrote 'there are no substantial recommendations or guidelines regarding the modification of warfarin and new oral anticoagulations (NOACs) prior to any type of ocular surgery. The decision to withhold, modify, or continue anticoagulation should be individualized'. The fact is that there are no standard recommendations whether to discontinue anticoagulant or antiplatelet agents in these patients when ocular surgery is performed, although it is generally agreed that cataract surgery,[2] and intravitreal injections are low-risk procedures for bleeding complications and discontinuation or modification is not needed.

Recent evidence-based guidelines recommend continuation of anticoagulants in patients undergoing cataract surgery provided that the international normalized ratio is in the therapeutic range and that aspirin be discontinued perioperatively only if the risk of bleeding outweighs its potential benefit.[3]

Although the 2009 meta-analysis found that, patients taking warfarin while undergoing cataract surgery had a three-fold increase of bleeding events compared to those not on warfarin, but the vast majority of bleeding events were self-limited, typically hyphemae or subconjunctival hemorrhage.[4] There was no evidence that continuing warfarin had a negative impact on postoperative visual acuity. Recent meta-analysis, including seventeen randomized controlled studies, reported no differences in the risk of substantial intraocular bleeding (that is, hyphema, vitreous hemorrhage, subretinal hemorrhage, and suprachoridal hemorrhage) between NOAs and other antithrombotic drugs.[5]

In summary, several studies show a higher incidence of subconjunctival hemorrhage in patients undergoing cataract surgery while taking antiplatelet or anticoagulant medication, but the available data do not show an increase in sight-threatening complications or decreased postoperative visual acuity.