prospective study, we allowed every patient experience with machine in form of test stimuli before starting the test and we would only start the real test once the patient feels comfortable with the whole procedure. We feel lack of familiarity with the machine will affect the mean retinal sensitivity. The authors have not mentioned the initial level of sensitivity they used as the MP 1 allows the examiner to select this setting before test is initiated. This is important as in patients with diabetic macular oedema with mean sensitivity of 2 dB. If the test was started at 16 dB, then it would take a longer time to complete the test. The prolonged time could result in decreased patient cooperation parameters such as false-positives or fixation stability and these parameters have not been reported in this study. This data would be helpful in interpreting the reliability of the results.

The 4-2 strategy is faster but we believe when measuring the macular sensitivity 4-2-1 strategy is superior. We did not understand the rationale behind using the 12° cross for fixation. It would have helped significantly if the authors compared the retinal thickness at each quadrant surrounding the fovea and correlated the retinal sensitivity to thickness both in diabetic macular oedema and normal eyes.

We read this paper with great interest and would like to once again congratulate the authors on their important work in establishing anatomic and functional correlation in the diabetic macular oedema eyes.

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Sir,

Response to Shah and Chalam

We appreciate the interest of Drs Shah and Chalam in our article and thank them for their comments. Our study was a pilot study to examine how the retinal sensitivity measured with the MP-1 correlates with other parameters, such as retinal thickness and visual acuity. From our experience, we feel that the testing conditions should be further modified especially for patients with poor visual acuity. In this study, the age of diabetic patients ranged from 25 to 76 years, and that of the controls from 42 to 76 years, as described in the Subjects and methods section. The reduced sensitivity may be due to the ages of the normal subjects. All tests were performed in a lighted room. In order to obtain more reliable data from patients with poor VA, we used a larger cross for fixation, and allow patients to learn the test. We also appreciate the other suggestions for further studies.

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Sir,

The subluxated lens: a patient's perspective

There are several camera systems available to the ophthalmologist for documenting ocular conditions. However, it is difficult to document what the patient

experiences. We describe a case of subluxated lens due to Marfan's syndrome from the patient's point of view.

Case report

In July 2003, a 60-year-old male was referred to the Vitreo-retinal Services of the Birmingham and Midland Eye Centre, Birmingham, UK for the management of subluxated lens in the right eye.

The patient complained of triple images when both eyes were open. The patient did not have any complaint with the right eye closed. Being a photographer, he was unable to do fine work with both eyes open. The best-corrected visual acuity was 5/60 and 6/6 in right and left eyes, respectively.

Slit-lamp examination of the right eye revealed an inferiorly subluxated lens with vitreous prolapse at the superior pupillary margin (Figure 1). The edge of the subluxated lens was close to the centre of pupil. There was iridodonesis, phacodonesis, and uneven deepening of the anterior chamber. The rest of the anterior segment examination was unremarkable. The left eye anterior examination was within normal limits. Intraocular pressure was 18 and 17 mmHg in right and left eyes, respectively. Fundus examination of both eyes was unremarkable. The patient underwent contact lens trial, but was dissatisfied. The patient underwent pars plana lensectomy, vitrectomy, and scleral-sutured lens implant for the right eye, and was very happy with the postoperative quality of vision.

The illustrations in this paper provided by the patient replicate the severely affected quality of his vision (Figure 2). He was able to create these images accurately, because he could compare with the normal image from his other eye (Figure 3). The photographic and computer skills of the patient played an important role in creating these images, which were prepared using Adobe

Figure 1 Anterior segment showing subluxated lens

Figure 2 As seen by eye with subluxated lens

Figure 3 As seen by patient's normal eye

photoshop software. (Full details of the exact computer process involved are available from the authors) (Figures 1–3).

Previous articles have highlighted the experiences of patients during various ocular operations.^{1,2} This paper illustrates the visual problems patients can have when the lens bisects the pupil. The severity of the image disturbance is much worse than we imagined from the clinical appearance and encouraged us to offer him surgery for his condition.

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Sir,
**Trypan blue-associated retinal toxicity post
complicated cataract surgery**

Case report

A 30-year-old Chinese female consulted for progressive blurring of vision of the right eye after sustaining a blunt injury 1 year prior. On examination, best-corrected visual acuity (BCVA) was 20/70. Pupillary responses were normal. There was an iridodialysis and subluxation of the cataractous lens. The posterior segment was unremarkable.

Trypan blue (0.06%) (VisionBlue[®], DORC International, Netherlands)—enhanced phacoemulsification was performed using a temporal clear corneal approach. The anterior chamber was filled with sodium hyaluronate 3%-chondroitin sulphate 4% (Viscoat[®], Alcon Ophthalmic, Fortworth, TX, USA). Trypan blue was injected directly over the anterior capsule, avoiding the area of zonulysis. However, the dye was noted to enter the vitreous cavity from the area without clinically evident zonulysis posterior to the corneal incision. Irrigation was immediately carried out with balanced salt solution to remove excess dye. The loss of red reflex made phacoemulsification and the visualization of the capsular bag very difficult. After a Cionni 1L capsular tension ring (Morcher[®] Cionni capsular tension ring, FCI-Ophthalmics Inc., MA, USA) was inserted and scleral fixated at the 2 O'clock position with 10–0 prolene under a scleral flap, an acrylic lens was implanted in the capsular bag. The iridodialysis was simultaneously repaired with 10–0 prolene. As there was no vitreous presentation, vitrectomy was not performed.

On the first postoperative day (POD), the visual acuity was 20/50. A grade 1 relative afferent pupillary defect (RAPD) was noted. The vitreous cavity had a moderate bluish hue that persisted until the fourth POD. (Figures 1

Figure 1 Slit lamp examination on the first postoperative day shows a uniform bluish fundal glow.

Figure 2 Fundal examination shows a moderate bluish hue in the vitreous cavity.

and 2) There was no macular oedema or other fundus lesions. Multifocal ERG (mfERG) showed reduced foveal P1 response without significant delay in implicit time (IT). Full field scotopic and photopic responses were subnormal without significant delays in IT.

At 1 month, BCVA was 20/20; the RAPD had resolved. Repeated testing showed normal photopic a-wave amplitudes and near normal photopic b-wave and 30 Hz flicker amplitudes.

Comment

Our patient presented with transient decrease in retinal responses post phacoemulsification, for which we suggest a multifactorial aetiology.

Inadvertent vitreous staining has been reported in cases with presumed zonular weakness post-trauma.^{1,2}