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The authors have no proprietary interest in any of the materials used in this study

Eye (2006) **20**, 1488–1490. doi:10.1038/sj.eye.6702392;
published online 28 April 2006

Sir,
Wound integrity and the conjunctiva in prevention of endophthalmitis following sutureless 25-gauge vitrectomy

I wish to thank Drs Taylor and Aylward for describing their case of presumed bacterial endophthalmitis following 25-gauge vitrectomy.¹ Discussion of complications or untoward outcomes ultimately leads to improved patient care.

It would be interesting to know whether scleral depression for examination of the periphery was performed during this case. When performed near the site of a 25-gauge cannula, this technique necessarily causes the cannula to be redirected anteriorly. If the cannula is plugged, this might not disrupt the sclerotomy, but if the cannula contains an instrument in active use such as the vitreous cutter, the manipulation of the instrument could be at odds with the anterior misdirection of the cannula. The consequence could be enlargement of the sclerotomy wound or at least distortion of the normal wound architecture. Similarly, scleral depression can tear the conjunctiva by pulling it posteriorly while it remains anchored

at the 25-gauge cannula. From any of these scenarios, one could envision an increased risk of subclinical wound leak.

Reference

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Eye (2006) **20**, 1490. doi:10.1038/sj.eye.6702395;
published online 28 July 2006

Sir,
Reply to Dr Stewart: prevention of endophthalmitis following sutureless 25-gauge vitrectomy

I thank Dr Stewart for his interest in this case. We only performed scleral indentation at the end of the case to check the ora serrata near the entry sites, and during this procedure the cannula was plugged. The procedure was completely routine in every aspect, so we do not believe there were any case-specific risk factors for endophthalmitis. We remain concerned as to whether there is an increased risk of infection associated with the use of sutureless vitrectomy systems, and await further data from case reports and future trials.

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Eye (2006) **20**, 1490. doi:10.1038/sj.eye.6702396;
published online 5 May 2006