antibiotics. In our case the small, localised abscess was confined to the site of the subtenon injection, required no drainage, and resolved on oral and topical antibiotics.

The current report while illustrating the efficacy of local steroid in the treatment of intermediate uveitis highlights a further late potential complication of subtenons injection. Further studies comparing the safety and efficacy of different routes of periocular steroid administration and routine use of povidine iodine preoperatively and more prolonged course of topical antibiotics following subtenons injection may be warranted to assess and minimise the risk of this rare complication.

References

1 Tanner V, Kanski JJ, Frith PA. Posterior sub-Tenon's triamcinolone injections in the treatment of uveitis. *Eye* 1998; **12**(4): 679–685.
2 Schlaegel Jr TF, Weber JC. Treatment of pars planitis, II: corticosteroids. *Surv Ophthalmol* 1977; **22**: 125–130.
3 Godfrey WA, Smith RE, Kimura SJ. Chronic cyclitis: corticosteroid therapy. *Trans Am Ophthalmol Soc* 1976; **74**: 178–188.
4 Helm JH, Holland GN. The effects of posterior subtenon injection of tramcinolone acetonide in patients with intermediate uveitis. *Am J Ophthalmol* 1995; **120**: 55–64.
5 Herschler J. Increased intraocular pressure induced by repository corticosteroids. *Am J Ophthalmol* 1976; **82**: 90–93.
6 Kim T, Rapuano CJ, Rodman RC, Vander JF, Cohen EJ. Conjunctival necrosis following the administration of subconjunctival corticosteroid. *Ophthalmic Surg Lasers* 1998; **29**: 79–80.
7 Rubinstein A, Hanson RJ, Chen SDM, Porter N, Downes SM. Conjunctival ischaemia subsequent to posterior subtenon's triamcinolone acetonide injection. *Eye* 2006; **20**: 388–389.
8 Engleman CJ, Palmer JD, Egbert P. Orbital abscess following subtenon triamcinolone injection. *Arch Ophthalmol* 2004; **122**: 654–655.

P Azarbod, Q Mohammed, I Akram and C Moorman

Department of Ophthalmology, Stoke Mandeville Hospital, Mandeville Road, Aylesbury, Bucks HP21 8AL, UK

Correspondence: P Azarbod,
Tel: +44 129 631 5034;
Fax: +44 129 631 5037.
E-mail: parhamazarbod@yahoo.co.uk

Eye (2007) **21,** 672–674. doi:10.1038/sj.eye.6702671; published online 15 December 2006

Sir,

Posterior polar cataract: minimizing risk of posterior capsule rupture

I read with interest the recently published article by Siatiri and Moghimi who performed a preferred technique of phacoemulsification in eyes with posterior polar cataract. This is the first study reporting not a single incidence of posterior capsule rupture associated with phacoemulsification of posterior polar cataracts.[1] This is an interesting finding given that has been hypothesized that occasionally the posterior capsule is deficient in the region of the polar opacity.[2–4] This study with 38 cases, however did not find this to be true. The absence of posterior capsule rupture is a remarkable result. I did however feel that some issues that may effect the outcome warrant further discussion.

We are aware that 38 eyes of 23 patients were included in the study. However, information about patient selection, co-existent or previous ocular disease, or surgical intervention, which may influence surgical outcome and an exclusion criteria, would be relevant in interpreting the results. Similarly, no details were provided regarding the possible incidence of other complications excluding posterior capsule rupture following the preferred surgical technique. The range in follow-up period of between 2 and 20 months suggests that further management may have been required for some patients.

Though this technique did prove to be safe, pertaining to the rate of posterior capsule rupture, we are unable to accurately estimate the treatment effect without a comparison to a standard reference by the same surgeon. As we become more aware of the predisposition to posterior capsule rupture with posterior polar cataracts and take the necessary preoperative and intraoperative precautions to minimize the complications, could it be that if the same surgeon had performed careful standard surgery, the incidence of posterior capsule rupture would have been as similarly low.

References

1 Hayashi K, Hideyuki H, Nakao F, Hayashi F. Outcomes of surgery for posterior polar cataract. *J Cataract and Refract Surg* 2003; **29**: 45–49.
2 Hejtmancik JF, Datilles M. Congenital and inherited cataracts. In: William Tasman, Edward A Jaeger (eds). *Duanes's Clinical Ophthalmology.* Lippincott Williams and Wilkins: Baltimore, 2001 vol 1, chapter 74.
3 Allen D, Wood C. Minimizing risk to the capsule during surgery for posterior polar cataract. *J cataract and Refract Surg* 2002; **28**: 742–744.
4 Robert H, Osher M, Bernard CY, Yu MD, Douglas D, Koch MD. Posterior polar cataracts: a predisposition to

intraoperative posterior capsular rupture. *J Cataract and Refract Surg March* 1990; **16**: 157–162.

M Subash

Royal Eye Unit, Kingston Hospital, Galsworthy Road, Kingston Upon Thames, Surrey KT2 7QB, UK

Correspondence: M Subash,
Tel: +44 78 7946 8107;
Fax: +44 20 8934 3266.
E-mail: malavika_subash@hotmail.com

Eye (2007) **21,** 674–675. doi:10.1038/sj.eye.6702677; published online 16 February 2007

Sir,

Reply

We greatly appreciate Subash's kind comments. Osher *et al*[1] reported a 26% incidence of capsule rupture in a series of 31 cases and Vasavada[2] reported a 36% incidence in his 22 cases. As we know with newer technique the reported rate of posterior capsule rupture has been reduced. For example, Hayashi[3] showed low incidence of posterior capsule rupture (only 7.1).

In our study, there was not any co-existent or previous ocular disease (except two eyes with retinitis pigmentosa) or surgical intervention, which may influence surgical outcome. We have not any special exclusion criteria. We performed our procedure based on the technique that Dr Allen described.[4] Although it was better to conduct a randomised control trial, but our results was remarkable enough to document the safety and efficacy of the procedure.

We think in most cases the capsule underlying posterior cataract is not absent but tends to be unusually weak and this weakness could predispose to posterior capsular rupture with only a minimal trauma. So optimal surgery and avoiding the 'floppy' posterior capsule during operation may reduce posterior capsular rupture to nearly zero.

References

1 Osher RH, Yu BC-Y, Koch DD. Posterior polar cataracts: a predisposition to intraoperative posterior capsule rupture. *J Cataract Refract Surg* 1990; **16**: 157–162.
2 Vasavada A, Singh R. Phacoemulsification in eyes with posterior polar cataract. *J Cataract Refract Surg* 1999; **25**: 238–245.
3 Hayashi K, Hayashi H, Nakao F. Outcomes of surgery for posterior polar cataract. *J Cataract Refract Surg* 2003; **29**: 45–49.
4 Allen D, Wood C. Minimizing risk to the capsule during surgery for posterior polar cataract. *J Cataract Refract Surg* 2002; **28**: 742–744.

S Moghimi and H Siatiri

Farabi Eye Hospital, Tehran University of Medical Science, Tehran, Iran

Correspondence: S Moghimi, Farabi Eye Hospital, Tehran University of Medical Science, Eye Research Center, Quazvin Sq, Tehran, Iran
Tel: +982155416134;
Fax: +982155416134.
E-mail: sasanimii@yahoo.com

Eye (2007) **21,** 675. doi:10.1038/sj.eye.6702685; published online 16 February 2007

Sir,

Reply to Jones *et al*

We fully agree with the sentiments raised; however, the study was performed as a retrospective audit so unfortunately this information is not available.

To determine the false negative rate one would require a formal prospective audit protocol of the GPwSI practice, with referral of a set number of 'negative' patients to the glaucoma specialist to confirm the lack of glaucoma. This was not financially viable in this study.

LD Jones, R Robinson and NJ Cook

University Hospitals Coventry and Warwickshire NHS Trust, Clifford Bridge Road, Coventry, CV2 2DX, UK

Correspondence: LD Jones,
Tel: +44 7968 526184;
Fax: +44 2476 966512.
E-mail: lynval@doctors.org.uk

Eye (2007) **21,** 675. doi:10.1038/sj.eye.6702678; published online 9 February 2007