

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

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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 Vasavada² 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, Hayashi³ 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

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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.

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