

that tension from the temporal suture or a postoperative pressure rise may be responsible.

We recommend the following to reduce the risk of RK dehiscence for patients undergoing cataract surgery. While a clear corneal incision may be acceptable if there is sufficient distance between the RK incisions for one to be made without intersecting an RK incision, a scleral tunnel should be considered.^{2,4} The advantage being the internal wound will be further away from RK cuts compared to that of a corneal incision. The scleral tunnel should be sufficiently short so that the cornea is not distorted perioperatively, but also long enough that the internal wound is far away from the RK incisions. If a corneal incision is used and there is an astigmatic keratotomy incision parallel to the main wound, suture closure of the main wound should only be used if essential. Postoperative topical or oral intraocular pressure prophylaxis should be considered to help prevent pressure spikes. Patients should have a first day postoperative review, even if their surgery is uneventful, to look for delayed RK dehiscence as occurred in our patient.

References

- Chen L, Mannis MJ, Salz JJ, Garcia-Ferrer FJ, Ge J. Analysis of intraocular lens power calculation in post-radial keratotomy eyes. *J Cataract Refract Surg* 2003; **29**: 65–70.
- Budak K, Friedman NJ, Koch DD. Dehiscence of a radial keratotomy incision during clear corneal cataract surgery. *J Cataract Refract Surg* 1998; **24**: 278–280.
- Behl S, Kothari K. Rupture of a radial keratotomy incision after 11 years during clear corneal phacoemulsification. *J Cataract Refract Surg* 2001; **27**: 1132–1134.
- Freeman M, Kumar V, Ramanathan US, O'Neill E. Dehiscence of radial keratotomy incision during phacoemulsification. *Eye* 2004; **18**: 101–103.
- McNeill JJ. Corneal incision dehiscence during penetrating keratoplasty nine years after radial keratotomy. *J Cataract Refract Surg* 1993; **19**: 542–543.
- Uchio E, Kadonosono K. Are airbags a risk for patients after radial keratotomy? *Br J Ophthalmol* 2001; **85**: 640–642.
- Casebeer JC, Shapiro DR, Philips S. Severe ocular trauma without corneal rupture after radial keratotomy: case reports. *Refract Corneal Surg* 1994; **10**: 31–33.
- McDermott ML, Wilkinson WS, Tükel DB, Madion MP, Cowden JW, Puklin JE. Corneoscleral rupture ten years after radial keratotomy. *Am J Ophthalmol* 1990; **110**: 575–577.

A Day and H Seward

The Eye Unit, Mayday University Hospital,
530 London Road,
Croydon CR7 7YE, UK

Correspondence: A Day
Tel: +44 20 8401 3127;

Fax: +44 20 8401 3607.
E-mail: alex@acday.co.uk

Eye (2007) **21**, 886–887; doi:10.1038/sj.eye.6702762;
published online 2 March 2007

Sir,
Adherence to College biometry guidelines

One of the purposes of the National Biometry Audit¹ was to enhance awareness of the Royal College guidelines on biometry formulae. It is therefore worth highlighting that the guidelines stated in the National Biometry Audit II² are not the most up-to-date ones from the College. The current guidelines³ suggest, among other possibilities, that the SRK/T formula may be used for all axial lengths. The ease of using one formula for all patients is likely to make compliance with the guidelines even better.

References

- Gale RP, Saha N, Johnston RL. National biometry audit. *Eye* 2004; **18**(1): 63–66.
- Gale RP, Saha N, Johnston RL. National biometry audit II. *Eye* 2006; **20**(1): 25–28.
- <http://www.rcophth.ac.uk/docs/publications/CataractSurgeryGuidelinesMarch2005Updated.pdf>.

N Ali

Royal Victoria Infirmary, Newcastle upon Tyne, UK

Correspondence: N Ali,
Royal Victoria Infirmary, Queen Victoria Road,
Newcastle upon Tyne, Tyne and Wear NE1 4LP, UK
Tel: +44 796 755 0929;
Fax: +44 796 755 0929.
E-mail: nadeem.ali@nhs.net

Eye (2007) **21**, 887; doi:10.1038/sj.eye.6702766;
published online 2 March 2007

Sir,
Adherence to college biometry guidelines

Thank you for your observation that the Royal College of Ophthalmologists (RCOphth) guidelines on IOL formulae quoted in the National Biometry Audit II paper¹ are not the same as the current RCOphth guidelines.² This is because the guidelines changed in the interval between acceptance of this paper and its publication. While all modern formulae achieve good

results in the common axial length range (when *A* constants are customised separately for IOL Master or ultrasound biometry), it is of interest to note, for example, that an eye with an axial length of 21.00 mm and *K* values of 7.80 mm, the Hoffer *Q* and SRK/T formulae recommend IOL powers of 32D and 31D, respectively, to achieve emmetropia, which suggests that for short eyes different formulae are not likely to be equally accurate. Large data sets of short or long eyes are needed to prove the superiority of one or other formula for eyes at the extremes of the axial length range and the Cataract National Dataset in the UK will be one way of achieving such data sets.

References

- 1 Gale RP, Saha N, Johnston RL. National Biometry Audit II. *Eye* 2006; 20(1): 25–28.
- 2 <http://www.rcophth.ac.uk/docs/publications/CataractSurgeryGuidelinesMarch2005Updated.pdf>.

RL Johnston

Cheltenham General Hospital, Ophthalmology Department, Cheltenham, Glos GL537AN, UK

Correspondence: RL Johnston

Tel: +44 1242 272529;

Fax: +44 8454 222585.

E-mail: rob.johnston@glos.nhs.uk

Eye (2007) 21, 887–888; doi:10.1038/sj.eye.6702765; published online 2 March 2007

Sir,

***NEMO* mutational analysis in a Japanese family with incontinentia pigmenti**

Incontinentia pigmenti (IP), also known as Bloch–Sulzberger syndrome, is an X-linked

