aetiological factor as the upper incisors were most affected in our patient.[5] When prescribing oral tetracycline for the treatment of blepharitis in adult patients, it is important to advise on oral hygiene measures and on avoidance of sunlight to minimize staining of teeth. Patients should also be reassured that the stain may be removed with abrasive cleansing by dental surgeon.

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Financial and proprietary interest: nil

Eye (2007) **21,** 1440–1441; doi:10.1038/sj.eye.6702957; published online 17 August 2007

Sir,

Risk factors for endophthalmitis: does non-wearing of face-masks increase relative risk?

As non-wearers of surgical masks, we were interested to read the editorial by Trivedi and Wilson[1] recommending the use of face-masks during cataract surgery. The immediate evidence for this recommendation was the multivariate analysis of retrospectively reported risk factors for postoperative infective endophthalmitis (PIE) from the British Ophthalmic Surveillance Unit, reported by Kamalarajah *et al*.[2]

The evidence for the use of face-masks in surgery generally is poor, with no effect on theatre air bacterial counts[3] and no effect on wound infection rates in a major randomised controlled general surgical trial.[4] Culture plates placed around the patient during cataract surgery without masks have been shown in one study to have increased bacterial cell counts,[5] but there are no prospective studies of face-mask use and PIE. It would be surprising to find a greater effect from mask use in the prevention of PIE than pertains in general surgery, given that the majority of PIE organisms are presumed to originate from the patients' conjunctival flora.

Where the evidence for benefit is uncertain, it is appropriate to assess adverse effects. Theatre masks increase condensation on operating microscopes and may impair the surgeons' view. Masks may rub on the face, thus displacing facial skin squames onto the operative site. Unnecessary use is inconvenient, wasteful, and impairs communication. In the absence of direct evidence of harm, we consider it reasonable to continue our current practise of not wearing face-masks in theatre.

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Eye (2007) **21,** 1441; doi:10.1038/sj.eye.6702966; published online 31 August 2007

Sir,

Reply to: Risk factors for endophthalmitis: does non-wearing of face-masks increase relative risk?

We thank Leyland and colleagues for sharing their views on the use of face-masks during ophthalmic surgery. As stated in our editorial, the wearing of face-masks during an operation to prevent potential microbial contamination of the incision is a long-standing surgical tradition.[1] However, many well-meaning traditions have inconclusive evidence of benefit underlying them. It is proper to challenge those traditions and critically examine the scientific evidence for continuing them.

We recommended, in our editorial, the proper use of face-masks based on studies such as the prospective randomized study by Alwitry *et al*,[2] which reported in the ophthalmic literature, significantly fewer bacterial counts from blood agar plates placed adjacent to the patient's head in the operating field when the surgeons

wore face-masks compared to the group that did not wear masks. Also, the recently published retrospective analysis by Kamalarajah *et al*[3] found the use of face-masks by the scrub nurse and surgeon to be protective against postoperative endophthalmitis after cataract surgery ($P<0.001$). We recognize that these data do not conclusively show that face-masks lower the risk for endophthalmitis. In fact, a Cochrane review found no conclusive evidence that wearing face-masks increases or reduces the number of surgical wound infections.[4] Until further research is done, there is no scientific mandate for or against face-masks during cataract surgery. We respect the decision made by Leyland and colleagues to continue not wearing them. For us, however, the severe potential consequences of endophthalmitis and the possibility of even a small protective influence from face-masks drives our continued recommendation to use them.

Acknowledgements

This study was supported in part by NIH Grant EY-14793; Grady Lyman Fund of the MUSC Health Sciences Foundation; and an unrestricted grant to MUSC-SEI from Research to Prevent Blindness, Inc., New York, NY, USA.

The authors have no financial or proprietary interest in any product mentioned herein.

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Eye (2007) **21,** 1441–1442; doi:10.1038/sj.eye.6702967; published online 31 August 2007

Sir,

Transconjunctival sutureless vitrectomy: comment on O'Reilly and Beatty

I congratulate O'Reilly and Beatty on their article on transconjunctival sutureless vitrectomy (TSV).[1] They provide useful surgical tips. I would like to add some tips, having extensively used this system for over four years.

TSV is applicable to the majority of vitrectomy procedures (over 80%). Limited exceptions include silicon oil use, requirement for 20 g instruments, eg a fragmatome or curved instruments. Finally, in cases requiring extensive anterior work, such as vitreous base excision, 20 g is preferred.

Insertion of the cannulae can be initially difficult. The preferred technique is to raise the bottle to 70 cm after infusion placement, plug the second entry, insert the third cannula, then lower the bottle to 55 cm. Also, counter-pressure with a blunt instrument, depressing the sclera in the equatorial region diametrically opposite to the insertion site stabilises the eye. Once the exposed metallic part of the trocar is through the conjunctiva, increased resistance is felt as the polyamide cannula is manoeuvred through; a brisk rotary 'drilling' movement facilitates this part of the entry, avoiding deformation of the eyeball. With a phacovitrectomy, one can place the infero-temporal

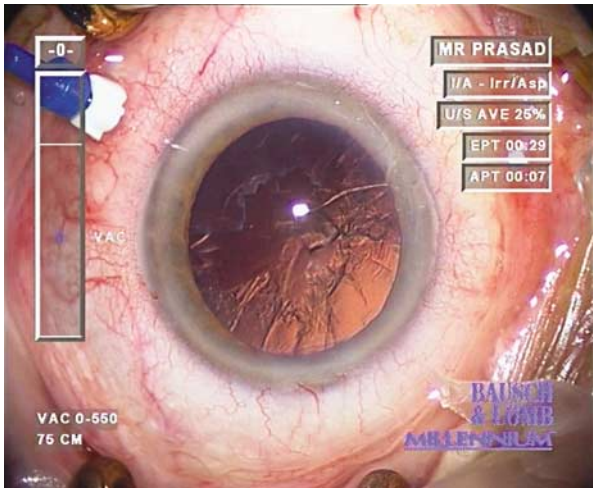

Figure 1 Preplaced infusion port. Phacoemulsification is completed with easy access.

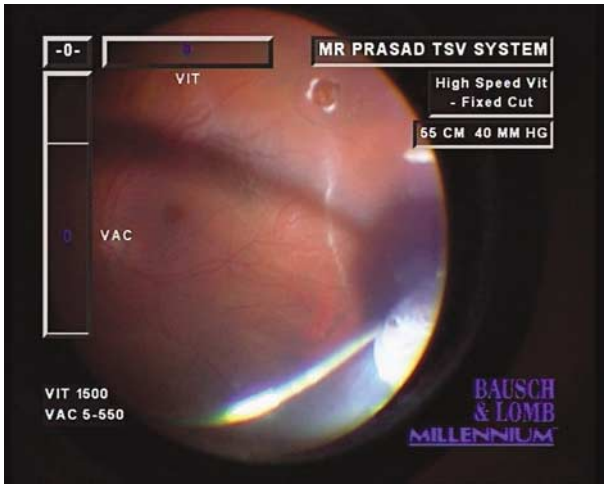

Figure 2 A chandelier light and indentation allows access to a small peripheral retinal hole.