Sir,
Side-saddle cataract surgery for patients unable to lie flat: learning from the past

I was interested to see Nair and Rimmer's report of 'side-saddle' positioning for phacoemulsification in patients who are unable to lie flat.¹ I have been using a virtually identical technique for the last 2 to 3 years,² and I suggest some refinements. Topical-intracameral anaesthesia allows the patient to fixate the operating light and therefore keep the eye still, in the desired position, with a good red-reflex. Surgery may be further facilitated by a face turn, and/or chin-up head positioning, if the patient is able to do this. With these adjustments, it is usually easy to make an on-axis incision, which may be inferior, temporal, or nasal, as required. Sometimes it is more comfortable for the surgeon to stand rather than to sit, facing the patient. The more upright the patient, the more the operating microscope must be turned towards the horizontal, and consequently the surgeon's arms will be more outstretched. With more extreme positioning, the outstretched arms can make surgery feel less controlled than normal: in these cases, I prefer to use a 'divide and conquer' technique with a straight second instrument, rather than risk iris trauma with an angled chopper. My personal practice is to use the 'standing-temporal approach'³ for most patients who cannot lie flat, and to reserve 'side-saddle' positioning for those who cannot adopt the required 'face to ceiling' position, or who need an inferior incision for astigmatism.

To illustrate the usefulness of the technique, I presented two of my patients to the 'difficult cases' discussion' at the 2007 annual meeting of the British Ophthalmic Anaesthesia Society. Both patients had severe Meniere's disease. The first, aged 83, needed seven pillows to sleep, would vomit if laid flatter, and had a previous cardiac procedure performed in the sitting position because of this. She also had angina, diabetes, and a hiatus hernia. The second patient, aged 82, would vomit and also have diarrhoea if laid flat (this is a recognised feature of Meniere's disease). She slept upright and also suffered from back pain and anxiety. The assembled audience of around 70 ophthalmic anaesthetists and ophthalmologists was unable to suggest any other safe approach to cataract surgery in these patients. Both of these patients had uneventful 'side-saddle' phacosurgery using topical-intracameral anaesthesia: the first had an on-axis infero-temporal incision with the patient seated almost upright (80° above the horizontal), and the second with an on-axis inferior incision, with the chair-back at 50° above horizontal. Both patients remained comfortable with no vomiting or other problems.

I agree that this technique can be very useful for those patients for whom the conventional positioning is not possible. It is not always as easy as phacoemulsification with the patient in the standard position, so it should only be attempted by the experienced surgeons.

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Eye (2008) **22**, 860; doi:10.1038/sj.eye.6703032;
 published online 16 November 2007

Sir,
Reply to 'Side-saddle cataract surgery for patients unable to lie flat: learning from the past'

We thank Eke for his comments and suggestions of refinements for this posture used for cataract surgery for patients unable to lie flat. The method he reported in the *American Journal of Ophthalmology* certainly has striking similarities, even to the figure of 60° for the angle of declination of the axis of the operating microscope. It is indeed reassuring to know that none hearing his presentation to the British Ophthalmic Anaesthesia Society was able to suggest a better surgical approach.

We admire his ability to adjust his incision to the steep axis. We concede that in these challenging cases, we position the section to make it most accessible to the surgeon. We also admire his stamina in preferring the 'standing-temporal' option, which we find uncomfortable because of having to bear weight on one leg in order to operate the pedals.

We checked why our literature search did not pick up Eke's paper. We originally submitted our work to *Eye* in April 2006, two months before his paper was published. Nevertheless, we cordially salute his priority of authorship.

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Eye (2008) **22**, 860; doi:10.1038/sj.eye.6703033;
 published online 16 November 2007

Sir,
OCT III imaging of whiplash maculopathy

We describe the fundus microscopy and the macular optical coherence tomography findings in a patient presenting with a unilateral paracentral scotoma following a whiplash injury.

Case report

A 24-year-old female suffered a car accident, inducing an extension–flexion movement of the neck. Within hours after the accident, she noted a paracentral scotoma in the left eye. Fundus examination of the affected eye

Figure 1 (a) A left inferior paracentral scotoma is delineated using a laser beam and a Maddox cross. (b) Quantified Octopus automated perimetry (10-degree centromacular field) showing a deep sensitivity loss, left inferior to the fixation point. (c) Fundus photography of the left eye showing a perifoveal lesion 6 months after a whiplash injury. (d) Stratus OCT III imaging (Line program), showing a thin hyperelective parafoveal lesion at the vitreoretinal interface.

demonstrated a macular swelling without posterior vitreous detachment. Six months later, the patient was referred to our clinic. She complained of a persistent scotoma close to her fixation area. Visual acuity was 20/20 in both eyes. However, using a laser beam, we revealed a left inferior paracentral scotoma, about 2 degrees in diameter (Figure 1a). Automated perimetry (Octopus 101, Interzeag) showed a loss in sensitivity at the nearest test location, left inferior to the fixation point (Figure 1b). Fundus examination revealed a whitish annular perifoveal lesion (Figure 1c). Macular optical coherence tomography (Stratus OCT III, Carl Zeiss) showed a hyperelective membranous lesion at the vitreoretinal interface (Figure 1d).

Comment

Very few cases of whiplash maculopathy have been described since it was first reported some 30 years ago.^{1,2} Although whiplash is a common injury in motor vehicle crashes, whiplash maculopathy is rarely reported, probably due to underdiagnosis.² We describe here a perifoveal lesion associated with this condition. The annular aspect of the lesion in fundus microscopy and its localisation at the vitreoretinal interface, demonstrated by OCT, support the role of vitreoretinal traction as presumed pathophysiologic mechanism. However, the thin membranous lesion described does not entirely explain the deep sensitivity loss measured by quantified perimetry, suggesting an underlying retinal damage, probably resulting from vitreoretinal traction and/or shearing forces. Recent results of macular histological

examination following a fatal whiplash injury support the pathogenic role of vitreoretinal traction in photoreceptors' disruption.³

OCT can be useful in the detection of lesions at the vitreoretinal interface related with whiplash maculopathy, providing us with a supplementary tool in the diagnosis of this frequently under-recognized condition. Moreover, OCT findings emphasise the role of vitreoretinal traction in the pathogenesis of whiplash maculopathy.

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Financial interest: None

Eye (2008) **22**, 860–861; doi:10.1038/sj.eye.6703093;
published online 1 February 2008