Sir,

Pseudophakic anterior chamber depth measurement

Nanavaty *et al*'s[1] hypothesis that a greater amount of post-phacoemulsification anterior capsule/intraocular lens overlap results in a greater amount of pseudophakic accommodation is intriguing and argued persuasively. However, despite their claims, to the contrary, IOLMaster (Carl Zeiss Meditec) measurements of anterior chamber depth (ACD), based on a slit lamp photographic technique, are generally considered unreliable in pseudophakic eyes[2,3] and we believe that this may confound their conclusions. As described, immersion ultrasound and partial coherence interferometry are the golden standards for pseudophakic ACD measurement.

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Sir,

Reply: Pseudophakic anterior chamber depth measurement

We thank Knox Cartwright and Tole for reiterating our discussion on the methodology involved in this study. As discussed in the paper, Zeiss AC Master (based on the principle of partial coherence interferometry) could have been a better alternative.[1] Zeiss AC Master is no longer available commercially and so slit-lamp assessment of anterior chamber depth remains one of the methods that can be used if anterior segment OCT[2] or ultrasound biomicroscopy[3] is not within practical reach. Moreover, the technique of anterior chamber depth measurement with IOL Master has already been reported to have a good reproducibility.[4] The authors had subjected all the patients to the standard technique so that any bias (if present) may be nullified and the validity of the results are not affected.

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Sir,

The use of Medpor-coated tear drainage tube in conjunctivodacryocystorhinostomy

Fan *et al*'s paper[1] on the use of Medpor-coated tear drainage tubes raises some important points regarding conjunctivodacryocystorhinostomy surgery. Jones in his original paper[2] describes how the tubes allow an epithelial-lined channel to form, connecting the conjunctiva to the nasal mucosa, and in effect keeping the tube outside the body. Porous polyethylene coating of the tube may allow fibrovascular ingrowth, but it simultaneously prevents a continuous epithelium forming, and therefore violates the basic surgical principle of implantable material being beneath a continuous epithelium to prevent infection. The high rates of conjunctival and nasal mucosal overgrowth found with these tubes, largely pyogenic granuloma formation, are the anticipated response to persistent inflammation and low-grade infection. The situation is analogous to pegging of porous orbital implants to increase prosthesis motility, rarely performed now due to the risk of infection and implant extrusion.

Jones[2] in the same study went further in suggesting that with time many patients would be able to dispense with their tube altogether. In practice, this is rarely the case, and most surgeons aim to retain the tube long term. As described by Rose and Welham ,[3] in what is probably the largest series (326 eyes) and longest follow-up (up to 23 years) of conventional Jones tube placements, problems with the tubes are common. At the mean time from tube placement of 1.3 years in Fan *et al*'s[1] paper, the

lower replacement rate of Medpor-coated compared to convention tubes(3.8 *vs* 26%) is seen to be at the expense of increased conjunctival overgrowth (23 *vs* 5.7%), and the overall rate of complications is therefore in fact comparable with conventional tubes. Medpor-coated tubes fail even to meet two of the key features of an ideal tube proposed by the authors (easy to insert and removable for cleaning if necessary). They appear to have little to recommend them.

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Sir,

Reply to Pearson

We all known that the ideal bypass tube should be hydrophobic, and there should be some rigidity, good biocompatibility, and less displacement or extrusion. It can be made up of various materials. Although the pyrex tube is successful in the majority of patients in relieving tearing, the main shortcoming of a Jones tube is extrusion. Using the Medpor tube as bypass tube, an improvement or complete relief of epiphora was achieved in most cases, and the tube extrusion or displacement was not seen in our study, although the rate of tube obstruction was higher than that reported in earlier studies.

Many doctors try to find an ideal bypass tube, but unfortunately all forms of artificial tear drainage replacement may be associated with either short- or long-term complications. It is still a hard and challenging work for all ophthalmologists.

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Sir,

Correspondence to case report titled: use of pegaptanib in the treatment of vitreous haemorrhage in idiopathic retinal vasculitis

I thank the authors for this interesting case report published recently.[1] There are a few questions that need to be addressed including systemic work-up. The 'vague' nature of his presentation may have indicated a detailed medical history and referral to the physicians. Abdominal symptoms could indicate either liver or renal dysfunction and in such cases routine blood and urine tests to look for abnormal liver function tests and proteinuria as well as abdominal ultrasound are justified.

Although Eales disease is a diagnosis of exclusion, a history of contact with persons with active-treated tuberculosis and travel in 'at risk' areas needs to be elucidated.[2] Systemic tuberculosis in an important condition to exclude and immunological tests such as the Mantoux test have a tendency to give variable results.[3]

We have previous experience of a case of a 25-year Caucasian man who presented with similar ocular symptoms and signs. His disease followed an aggressive course despite immunosuppressive medical therapy, laser treatment and vitreoretinal surgery. Our patient had abnormal liver function tests and proteinuria consistent with wide-spread tissue involvement with a negative Mantoux test. Prompt referral to the physicians following medical investigations with tuberculosis immunospot test demonstrated reactivity against *Mycobacterium tuberculosis* with significant response to triple therapy.[4] We therefore suggest early referral to physicians in those patients with ischaemic vasculitis and systemic symptoms to exclude extrapulmonary tuberculosis as demonstrated in our case. Anti-VEGF agents have a specific activity to reduce oedema and inhibit angiogenesis and therefore therapy in the published case could have halted acute progression; however, it is possible that the disease process may have stabilized and resolved during the follow-up period.[5]

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