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Sir,

Cystoid macular oedema after selective laser trabeculoplasty

We report a case of cystoid macular oedema (CMO) after selective laser trabeculoplasty (SLT). An 89-year-old Caucasian woman with a previous complicated left cataract surgery was referred to our practice. Visual acuity was 6/12 in the right eye and 6/36 in the left eye. There was right cataract, a left posterior chamber intraocular lens with an absent posterior capsule, and left CMO (later confirmed on optical coherence tomography (OCT)).

She underwent right cataract surgery, while the left eye was treated with topical dexamethasone 0.1% q.i.d. and ketorolac q.i.d. Over 2 years, acuity in the left eye improved to 6/9; however, intraocular pressure (IOP) increased to 30 mm Hg. The topical steroid was ceased and topical brinzolamide (0.1% b.i.d.) commenced. On account of persisting elevated IOP and questionable compliance with brinzolamide, SLT was offered. Pre-laser acuity was 6/9 and IOP was 20 mm Hg on brinzolamide. A 180-degree inferior treatment was performed with 57 applications of 0.7 mJ and total energy of 40 mJ. There was no post-treatment uveitis.

The patient noticed decreasing vision and at 4 weeks acuity was reduced to 6/18. The IOP had improved to 10 mm Hg. Clinically, there was CMO, confirmed on OCT. Ketorolac drops q.i.d. were commenced and brinzolamide continued. Three weeks later acuity had improved to 6/6 with marked resolution of the macula both clinically and on OCT. The IOP remained at 12 mm Hg.

To our knowledge, this is the first reported case of CMO after SLT, which is considered a relatively safe and

innocuous procedure.^{1–3} As inflammatory processes may be inherent to its mechanism of action,³ we postulate that upregulation of inflammatory pathways could have triggered a recurrence of the CMO, especially with an absent posterior capsule, allowing greater access of inflammatory mediators to the posterior segment. Other inflammatory reactions to SLT are well recognised, such as ciliary injection and anterior chamber inflammation,^{1,2} and there is one report of choroidal effusion associated with severe inflammation.⁴

We recommend caution in using SLT in eyes with a tendency for developing CMO, especially if CMO has been prolonged or was associated with complicated cataract surgery. If SLT is required in such cases, one might consider pre-treating with a non-steroidal anti-inflammatory agent.

Conflict of interest

The authors declare no conflict of interest.

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Sir,

Simultaneous bilateral cataract surgery: a further advantage

We welcome the article by Nassiri *et al.*¹ Their paper lends further evidence to the growing body in support of simultaneous bilateral cataract surgery (SBCS).

As Nassiri *et al.* suggest, the main cited objection to SBCS is the very rarely reported (four cases in the literature) risk of bilateral simultaneous infectious endophthalmitis. Conversely, the advantages of SBCS have been repeated numerous times. We hypothesise a further advantage.

If we assume that a patient undergoing SBCS would have a clinic appointment, a biometry and assessment