appointment, surgery, and finally a post-operative visit, these patients would have had four appointments in total. Those undergoing conventional sequential surgery would have the same, followed by their second surgery and a final post-operative visit, totalling six visits. It has been suggested that the average round trip per hospital appointment is 56 miles.² This would lead to a total of 224 miles per SBCS patient (or 112 000 000 miles for 500 000 patients) and 336 miles per non-SBCS patient (168 000 000 miles for 500 000 patients). It is also suggested that there are 1.48 road fatalities per 100 000 000 miles of road travelled.³ This would lead to a total of 1.66 deaths on the roads per 500 000 patients undergoing SBCS compared with 2.49 deaths for the same number of patients undergoing conventional monocular surgery. This would increase to 2.9 deaths if patients have a second assessment between surgery (thereby totalling seven trips). There is, therefore, potentially 1.5–2 times the risk from death in a road traffic accident by undergoing extra visits for unilateral sequential cataract surgery in those suitable for SBCS. The patients in Nassiri's cohort who cited 'difficulty in travelling' as a reason for choosing SBCS may well have been very astute indeed.

In conclusion, the advantages of SBCS are numerous and well documented. The risks and disadvantages are few and sparsely reported. We would recommend that SBCS be considered more frequently for those patients who are suitable.

We challenge your readership with the following question: Which is worse—one case of bilateral simultaneous endophthalmitis or a dead patient from the extra visits for sequential surgery?

Conflict of interest

The authors declare no conflict of interest.

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Sir, Heavy internal tamponades and risk of hypotony

The recent publication by Li *et al* (*Eye*, E-pub 27 March 2009) on the complications associated with the use of Densiron 68 and other heavy internal tamponades necessitates a comment regarding the risk of hypotony. The authors summarize that, with the exception of our previous publication on perfluorohexyloctane (F6H8),¹ 'there is no indication for an increased risk of postoperative hypotony with heavy endotamponades'. This statement is misleading. With regard to F6H8, there are, in addition to our report, serious indications for an increased risk of hypotony.^{2–4} Altogether, these authors observed hypotony in 6 of 26 eyes (23%). In our series,¹ which is the one with the longest follow-up so far, it was evident that hypotonia developed progressively after the removal of F6H8 and was manifest in the majority of cases at the final 6-months examination. A progressive trend towards low mean intraocular pressure was also observed in the multicentre approval study on F6H8,⁵ which unfortunately covered only a postoperative period of 3 months.

Conflict of interest

The author declares no conflict of interest.

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