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SK Gibran and KG Kapoor

Department of Ophthalmology and Visual Sciences, The University of Texas Medical Branch at Galveston, Galveston, TX, USA.
E-mail: kgkapoor@utmb.edu

Eye (2010) **24,** 190–191; doi:10.1038/eye.2009.260; published online 30 October 2009

Sir,

Reply to Gibran and Kapoor

We appreciate the comments made by Drs Gibran and Kapoor[1] regarding our article 'Comparison of 25- and 23-gauge sutureless microincision vitrectomy surgery (MIVS) in the treatment of various vitreoretinal diseases'. We fully agree with their opinion that the proximity of the cutter port to the tip is one of the several important advantages of the Alcon 23-g cutter. As Drs Gibran and Kapoor mentioned, this port's proximity certainly allows vitreoretinal surgeons to perform a safe delamination or segmentation of the fibrovascular membrane in proliferative vitreoretinopathy (PVR). With the introduction of preoperative bevacizumab treatment, this feature became particularly useful in operating eyes with advanced fibrovascular diabetic traction retinal detachment (TRD).

Although we routinely use 23-g MIVS for delaminating and shaving the preretinal fibrovascular membrane in advanced diabetic cases, we only included milder diabetic cases in this prospective study because it was designed to randomize cases of either 23-g or 25-g MIVS. Instead, we added 'that the 23-g system would have been shown to be better than the 25-g technique if more advanced cases, such as those with diabetic TRD of moderate degree or worse, …, were included.'

In addition to the proximity of the tip, 23-g cutters have greater performance benefits over 25-g cutters because of their increased flow rates, duty cycle, cut rate, and instrument stiffness. Whereas the use of 25-g MIVS is still limited to less complicated vitreoretinal cases, the use of 23-g MIVS has been continuously increasing surgical efficiency and expanding surgical indications covering more advanced vitreoretinal cases of various causes.

Recently, Alcon introduced a new 25-g cutter, called ACCURUS 25+, which has improved nearly all the disadvantages 25-g had compared with 23-g. It has a higher speed cutting rate, better aspiration flow, improved duty cycle, stiffer needle, larger cutting port area, and cutting port closer to the end of the probe (Figure 1). This new 25+ probe may achieve the maximal surgical efficiency of MIVS, with minimal incision when obtaining transretinal choroidal biopsies of small tumours as well as when delaminating the preretinal fibrovascular membrane in eyes with advanced diabetic TRD or PVR, and much more.

With continuing advances in MIVS technology, we believe that such comparative studies should be updated accordingly.

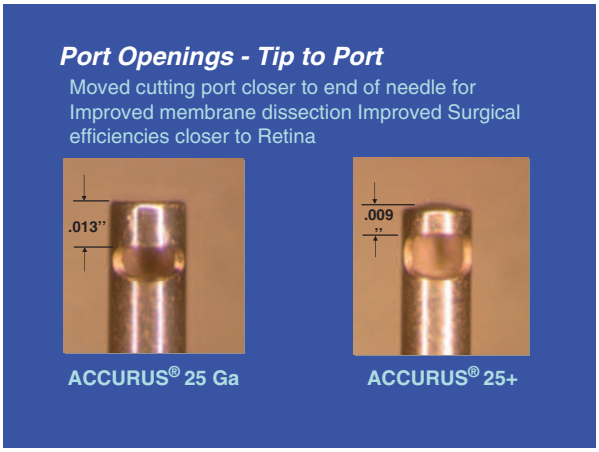

Figure 1 Comparison of Accurus 25+ with Accurus 25 Ga. Accurus 25+ has a larger port that was moved closer to the end of the tip. In addition, it has a higher speed cutting rate, better aspiration flow, improved duty cycle, and stiffer needle.

Conflict of interest

The authors declare no conflict of interest.

Reference

1 Gibran SK, Kapoor KG. Comparison of 25- and 23-gauge sutureless microincision vitrectomy surgery in the treatment of various vitreoretinal diseases (Correspondence). *Eye* 2010; **24**: 190–191.

Y Nam, H Chung, JY Lee, J-g Kim and YH Yoon

Department of Ophthalmology, College of Medicine, Asan Medical Center, University of Ulsan, Seoul, Korea
E-mail: yhyoon@amc.seoul.kr

Eye (2010) **24,** 191; doi:10.1038/eye.2009.290; published online 27 November 2009

Sir,

Comparison of 25- and 23-gauge sutureless microincision vitrectomy surgery in the treatment of various vitreoretinal diseases

We read with great interest the article 'Comparison of 25- and 23-gauge sutureless microincision vitrectomy surgery in the treatment of various vitreoretinal diseases' by Nam *et al*.[1] We have some questions and comments to share with the authors.

(1) We do not know how the authors made the main incision for phacoemulsification in those patients who underwent combined cataract surgery and vitrectomy. This is important, as the location and architecture of the main incision might affect the postoperative anterior segment scores and the development of postoperative hypotony.