

the capsular bag using a sealed-capsule irrigation device and 5-fluorouracil' by Milverton is of great interest, as irrigation of the capsular bag using the Milvella-sealed capsule irrigation device has the potential to destroy all lens epithelial cells without bystander damage in the rest of the eye. Previous attempts to hydrolyse lens epithelial cells in the bag using this device by irrigating with distilled water have failed, as residual cortical material appears to protect the equatorial cells. The author claims that irrigation with 5-fluorouracil prevented posterior capsule opacification in this case up to 1 year after surgery.

However, a careful perusal of the 12-month image shows that there is clearly fusion of the capsular bag around the intraocular lens haptics, which would suggest that viable lens epithelial cells are still present and that PCO may be delayed rather than prevented by irrigation with 5-fluorouracil.

#### Conflict of interest

The author declares no conflict of interest.

#### Reference

- 1 Milverton EJ. Irrigation of the capsular bag using a sealed-capsule irrigation device and 5-fluorouracil. *Eye* 2009; **23**: 1746–1747.

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Sir,  
**Reply to Mr Spalton**

The opinions expressed by Mr David Spalton<sup>1</sup> are absolutely correct.

There is apparent fusion of the anterior and posterior capsules, as stated. 5-Fluorouracil may well only delay the onset of PCO, however clinical trials need to be carried out to determine its long-term effectiveness in preventing PCO. Sealed irrigation of the capsular bag, under positive pressure to inflate the bag fully, using Perfect Capsule, should enable an irrigating solution to reach the equatorial cells, eliminating them and so hopefully ensuring a clear and supple capsule.

#### Conflict of interest

The author declares no conflict of interest.

#### Reference

- 1 Spalton DJ. Re: The report 'irrigation of the capsular bag using a sealed-capsule irrigation device and 5-fluorouracil' by Milverton. *Eye* 2010; **24**: 1298–1299 (this issue).

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Sir,  
**Medial and lateral rectus recession: a novel and rapid stepped technique**

The principle of muscle recession in squint surgery is to detach the muscle from the globe, then to reattach it at the pre-determined distance from the limbus with or without postoperative manipulation. In order to avoid excessive fibrosis and contracture of the muscle and adjacent tissues, this should be achieved with minimal trauma to the muscle and surrounding tissues. We describe a novel method of primary muscle recession that is used in our routine clinical practice.

#### Method

The conjunctiva and Tenon's capsule are raised as a flap and the muscle tendon is exposed at its insertion (Figure 1a). Light cautery is applied to the blood vessels at the insertion of the muscle tendon (Figure 1b). At 1 mm behind the insertion, one-third of the muscle tendon is secured (Vicryl 7-0, Ethicon, Spreintebach, Switzerland) using a locking suture (clove hitch knot, which consists of two half hitches made in opposite directions) (Figures 1c and 2a). Two-thirds of the width of the tendon is then detached from the globe, while the other third remains untouched (Figure 1d). Calipers are used to mark the desired amount of recession and the cut part of the tendon is reattached to the sclera. A spatulated quarter circle 6.0 needle is used to reattach the muscle by spreading the tendon through a 1.5–2-mm scleral passage (Figure 2b). The second part of the muscle is then recessed in a like manner (Figure 1e and f). The conjunctiva is then sutured with the 8-0 vicryl.

#### Discussion

Today, the most common technique of squint surgery is based on that of Helveston.<sup>1</sup> The squint hook is used to help recognise and stabilise the muscle, before it is detached from the globe. In our experience, during primary muscle surgery, fine-toothed forceps are all that is necessary to identify and secure the muscle tendon, without the need for a squint hook.

Our method has been used successfully for over 10 years. The maximum recession from this method is 6 mm. The main advantage is it minimises manipulation of the tissues and thus minimises fibrosis and scarring. In addition, it has fewer steps, is rapid to perform, and is easy to learn. The use of cautery, prior to any manipulation of the muscle, prevents bleeding and ensures good visibility throughout the procedure. The