In summary, I feel that there are many factors that should be considered when using phacoemulsification in a high-volume setting in developing regions, and a prospective comparative study would go a long way to answering these questions. Nevertheless, I congratulate the authors on their results and commend them for their good work in Nepal and India.

Conflict of interest
The author has no financial or proprietary interests.

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Sir,
Response to Dr Colin Tan

We are grateful to Dr Tan[1] for his interest in our report.[2]

We agree with Dr Tan that a small increase in unit cost can add up to a large increase in total cost in a high-volume setting. However, this must be set against the improved visual outcomes. In the largest clinical trial of phaco *vs* manual small-incision cataract surgery (MSICS), patients who had undergone phacoemulsification with a foldable IOL were significantly more likely to have a presenting visual acuity of 6/18 or better at 8 weeks after surgery than those having MSICS with a rigid IOL.[3]

There is increasing demand for phacoemulsification in poor and middle-income countries, both from patients and from ophthalmologists. This will lead to increased costs, and possibly to reduced numbers of surgeries because of this. The majority of the increased cost is due to the use of a much more expensive foldable intraocular lens.[4] The purpose of our small study is not to suggest that phaco should supersede MSICS in all cases, but rather that some of the benefits of phaco may be obtainable at significantly lower cost by using an inexpensive rigid IOL rather than a more costly foldable implant.

Dr Tan mentions that MSICS causes less post-operative corneal oedema, particularly in very dense nuclei. For this reason, all eyes likely to have hard nuclei had MSICS in this study.

Out of the 8410 phaco with 5-mm scleral tunnel incisions and rigid PMMA IOL, 24 (0.28%) required sutures to close the wound. Because this was a retrospective study, it was not possible to collect data on induced astigmatism. Although the 5-mm incision is larger, it is more posterior, and may cause no more astigmatism than the 3-mm clear corneal wound.

We are in complete agreement with Dr Tan that the best way to answer these questions is in a prospective study. We have recently obtained ethical approval for a prospective trial of rigid *vs* foldable IOL following phacoemulsification in Nepal, and we hope to begin recruitment later this year.

Conflict of interest
The authors declare no conflict of interest.

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