in the superficial fovea.² Kola nut ingestion was suggested as a potential cause. Subsequent reports of patients with similar clinical findings have expanded to other West African countries, including Liberia, Cameroon, Ghana, and Sierra Leone.^{1,3,4} A recent report showed the crystals to be in Henle's layer using optical coherence tomography.³ The pathogenesis of these crystals is unknown, although retinal vascular disease, with breakdown of the blood-retinal barrier, has been suggested as a possible cause.^{3,4} Regional food and diet peculiarities have also been considered as possible aetiologic agents.^{2,3}

In contrast to previously published cases of WACM, our patient originated from East Africa, in Egypt, a country which shares ethnic and historical connections with the Middle East and is culturally distinct from West Africa.⁵ Given the similarities of our East African patient to previously reported cases of WACM, we believe the more appropriate term for this condition may be African crystalline maculopathy.

Conflict of interest

The authors declare no conflict of interest.

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Sir,

Reply: the report 'Spontaneous dislocation of an Artisan phakic IOL causing corneal decompensation requiring an endothelial graft' by Harsum *et al*

We read with great interest this report describing spontaneous dislocation of an Artisan IOL.¹ As the authors suggest, this is a rare event and normally occurs following direct or indirect trauma. We were curious about their comments regarding the contralateral unaffected eye. The assertion has been made that there is decentration of this IOL and atrophic iris at the points of enclavation. Are the authors suggesting that this IOL is unstable?

Having used a large number of these IOLs in aphakic eyes, we would argue that the position of this IOL, although not perfectly centred, is completely acceptable. This IOL is unlikely to have moved since implantation. Artisan implantation is a fairly complex bimanual procedure. The centration of the Artisan IOL during insertion can be slightly variable and is influenced by several factors, including the effect of viscoelastic on anterior chamber depth, pupil size, and position. However, we have never known these small variations to affect final visual outcome. The enclaved iris in Figure 1b shows no clearly visible signs of atrophy as suggested.¹ On the right fixation point, the amount of enclaved iris seems just about adequate. The left fixation point I would describe as abundant!

True decentration of Artisan IOLs has been described involving a downward translation of the entire IOL haptic through the stroma of the enclaved iris.² The incidence has been reported as 2.5% over approximately 5 years. It was postulated that this might be secondary to stromal atrophy at the fixation points, which was quantified using anterior segment OCT. It appears this process can occur despite generous fixation, however, re-fixation of the haptics is not always necessary.

Conflict of interest

The authors declare no conflict of interest.

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