

a 4-h operating list when the majority of cases are ISBCS as opposed to unilateral surgery. The time saved is in moving patients in and out of theater and redundant paperwork. The comments on time from listing to surgery, and time from first to second eye surgery is likely to be very variable for multiple reasons. However, we are aware that within 16 miles of the authors' hospital the current waiting time for cataract surgery routinely exceeds 6 months.

In the final two paragraphs, the authors equate bilateral endophthalmitis with bilateral blindness. This extraordinary assumption would imply no treatment of this complication, which seems unlikely. Our experience is that the modern management of endophthalmitis leaves many eyes with useful, (and often excellent) vision, and to assume blindness shows a rather alarmist approach. In these closing paragraphs, the authors muse on 'Should bilateral same day cataract surgery routinely be offered to all?' We accept that they may have been asked to opine on this specific question, and may indeed have used the narrowness of the question to reply. We believe that ISBCS should be offered routinely to all appropriate patients, and that full consent and explanation of options should be offered. We believe that there are patients who should not have such surgery, but with increasing experience with ISBCS, as with any other procedure, the surgeon discovers that fewer and fewer patients fall into the routine exclusion group. However, ISBCS is currently routinely NOT offered to appropriate patients in the UK, and many other countries, despite peer-reviewed published evidence of effectiveness, economy, and very low risk. We would suggest that many patients would benefit if more ophthalmologists would remember to consider this option when listing patients for surgery.

#### Conflict of interest

The authors declare no conflict of interest.

#### References

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Sir,  
**Reply to Claoué et al**

We agree with many of the comments of the International Society of Bilateral Cataract Surgeons (iSBCS) and welcome the debate regarding what is best practice for patients and society.<sup>1</sup> However, many of the arguments made in this response have already been made in the 'Bilateral same-day cataract surgery should routinely be offered to patients – Yes' article,<sup>2</sup> accompanying our No argument.<sup>3</sup>

First, the common ground. We agree that there may be circumstances where immediate sequential bilateral cataract surgery (ISBCS) is in the best interests of the patient. We also agree that surgeons should not be financially penalised for ISBCS. When we state that interest in ISBCS is fuelled by potential economic benefits, it is the economic benefits for the social system as a whole to which we refer.

We also agree that the publications we reference show some medical benefit of ISBCS, however our argument is that the medical benefits are primarily transient if second eye surgery is performed. For example, attainment of normal stereopsis and binocular summation of visual acuity may be achieved more quickly with ISBCS but will also be achieved with an interval between surgeries. We are not aware of any publications discussing ISBCS that do not also discuss convenience and economy, and these issues are rightly discussed in our article.

We do not agree that other bilateral ocular procedures should be used as a model for ISBCS. It is perhaps misleading to liken ISBCS to bilateral ptosis or squint surgery, and even to bilateral retinal surgery, where the risk benefit ratios may be quite different to cataract surgery.

We agree that the evidence regarding potential risk factors for endophthalmitis is limited. However we prefer to err on the side of caution and treat patients' blepharitis prior to cataract surgery. Furthermore, the question of risk factors for endophthalmitis affects the suitability of an individual patient for ISBCS more than the wider debate, as to whether ISBCS is appropriate in the first place.

The authors refer to the waiting time for cataract surgery, which varies from region to region. A long wait between first and second eye cataract surgery is not ideal. However, if ISBCS were to be widely adopted, it is conceivable that the waiting time for first eye cataract surgery may actually increase due to the additional time required for the bilateral surgical procedure.

Mention is also made of the low incidence of endophthalmitis following ISBCS, however, much of this evidence is retrospective. A previous paper based on a survey of ISBCS surgeons stated that as 'each case represented a memorable event for the surgeon and it is unlikely that omissions were made in data collection'.<sup>4</sup> When introducing a new procedure into practice a more robust prospective evaluation would be better.

The precautions recommended by the iSBCS to reduce the risk of endophthalmitis should be commended, however, as they state, most cases of endophthalmitis emanate from the patient's own flora. Therefore

measures such as re-gloving, re-gowning, and using devices from different manufactures or batches may not prevent infection. By operating on both eyes at the same sitting it is logical that there is a potential increase in risk, particularly from sources such as airborne exposure in the operating theater.

We recognize that endophthalmitis does not equate to blindness, but it is a frequently devastating and best-avoided condition. Also, the argument against ISBCS is not one purely based on endophthalmitis, for example, deferring second eye surgery allows one to know the refractive results of the first eye and adjust IOL selection for the second.

We agree that ISBCS should be offered to appropriate patients, however, we disagree on the definition of appropriate. We recommend that ISBCS be offered to patients with a definite indication for ISBCS and not purely for those without a contraindication.

#### Conflict of interest

The authors declare no conflict of interest.

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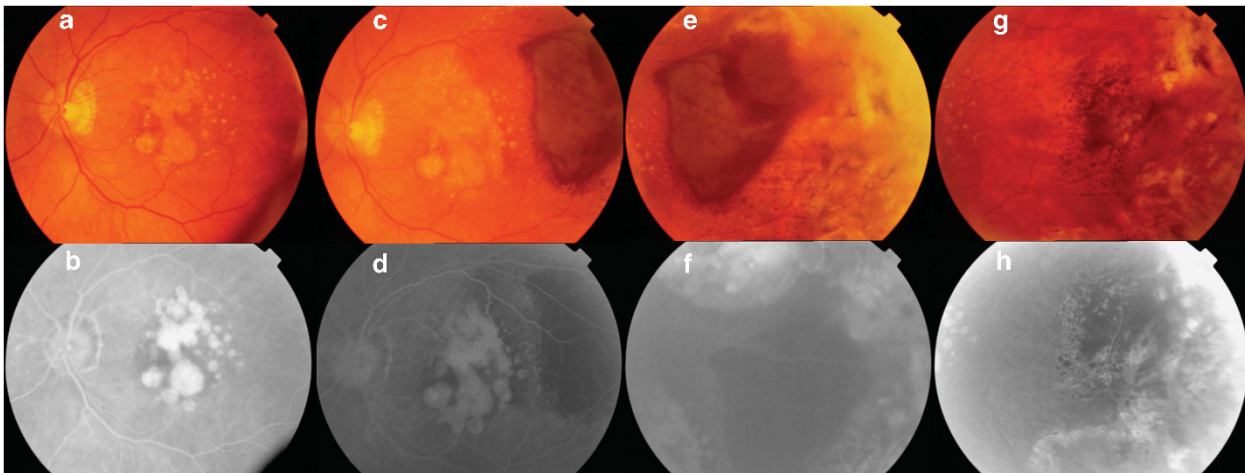
#### Sir, Clinical characteristics of peripheral exudative hemorrhagic chorioretinopathy and its response to bevacizumab therapy

Peripheral exudative hemorrhagic chorioretinopathy (PEHCR) is characterized by subretinal or sub-pigment epithelial hemorrhage and exudation localized outside the macular region.<sup>1</sup> PEHCR is thought to be a variant of age-related macular degeneration (ARMD),<sup>2</sup> but its neovascular origin is still controversial.

#### Case report

In this study, our aim was to evaluate the clinical features, prognosis, and response to intravitreal bevacizumab of PEHCR.

Twenty-three eyes of 15 patients with a diagnosis of PEHCR were included. The mean age of patients was  $82.4 \pm 5.8$  years (range 75–95). Nine (60%) of the patients were female. PEHCR lesions were often detected in the temporal quadrants (91.3%). Most eyes (78.2%) had a subretinal or sub-RPE (retinal pigment epithelium) hemorrhage followed by subretinal fluid. The bilateral involvement ratio was 37%. After  $32.6 \pm 4.8$  months of follow-up, PEHCR lesions were found to be stable and/or regressed, leading to RPE atrophy or a subretinal



**Figure 1** An 85-year-old woman with 0.4 LogMAR visual acuity in her left eye. (a) Color fundus photograph with geographic atrophy and drusen. (b) Fluorescein angiogram with corresponding window defect. (c) Two years later, visual acuity was 0.4 LogMAR. Color fundus photograph with increased geographic atrophy and a large mass of subretinal blood temporal to the macula. (d) Fluorescein angiogram with corresponding window defect and blockage defect. (e) A large mass of subretinal blood and exudates. (f) Fluorescein angiogram with a corresponding blockage defect and leakage along the edge of the lesion. (g) Three months after intravitreal bevacizumab, the mass-like lesion and exudates had regressed on the peripheral retina; visual acuity stayed the same. (h) Fluorescein angiogram with corresponding blockage and decreased leakage along the edge of the lesion that were detected.