Conflict of interest
The authors declare no conflict of interest.

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Sir,
Comment on 'Idiopathic uveal effusion syndrome causing unilateral acute angle closure in a pseudophakic patient'

I read with interest the above communication by Bhogal *et al*,[1] published recently in the *Eye* journal.

The authors presented images of B scan ultrasound, correctly demonstrating choroidal effusion as the primary trigger in precipitating angle closure glaucoma in their patient. The anterior segment OCT images however failed to show the anatomical mechanism of angle closure, which, in many cases, is caused by the anterior rotation of ciliary body and most probably associated with annular ciliary body detachment. These findings would have been best illustrated by high frequency ultrasound (HFU). The value of HFU in cases of pseudophakic pupillary block and other post-operative ciliary body abnormalities was demonstrated by us in previous publications.[2,3]

Anterior segment OCT is an 'optical scan' and therefore obeys the simple optical principle of inability to penetrate through opaque media. This is the domain of ultrasound. It is tempting to use anterior segment OCT in many clinical situations, as it is noninvasive and easy to use. Anterior segment OCT produces excellent images of the cornea, anterior iris tissue, trans-pupillary lens and angle configuration. It is however inferior to HFU in imaging of the posterior iris surface, ciliary body, posterior chamber, zonules, pars plana and periphery of choroid. An excellent prospective observational case series, comparing anterior segment OCT and HFU in the imaging of anterior segment masses, tend to confirm the above assertion and was published by Pavlin *et al*[4] in 2009.

It is reasonable to recommend to readers that whenever imaging of the ciliary body is desirable, then HFU should remain the technique of choice.

Conflict of interest
The author declares no conflict of interest.

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Sir,
Response to 'Shield or not to shield? Postoperative protection after modern cataract surgery'

We read with interest the correspondence by Lindfield *et al*[1] questioning the necessity for the routine use of shields after small incision cataract surgery following a retrospective review of local practice, and feel that it raises an interesting point. We would, however, request clarification of a potential confounding factor that was not included in the reported data. The authors make no comment regarding the proportion of corneal sections that were sutured. If either group is disproportionately weighted to using corneal sutures, this could either further strengthen or weaken the author's argument.

Secondly, a 2003 ASCRS survey[2] showed that 72% of small incision cataract surgery was performed through a clear corneal section with only 28% through a scleral tunnel (no UK data available). The cohort of Lindfield *et al*[1] had a disproportionately high percentage of scleral tunnel patients compared with likely current standard practice.